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SOVIET PSYCHIATRIC PRACTICES

JULY 12, 1989

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PUBLIC HEARING ON SOVIET PSYCHIATRIC PRACTICES

WEDNESDAY, JULY 12, 1989

COMMISSION ON SECURITY AND COOPERATION IN EUROPE

Washington, DC

The Commission met, pursuant to notice, in room 562, Dirksen Senate Office Building, at 2 p.m., Senator Dennis DeConcini, Chairman, and Representative Steny H. Hoyer, Cochairman, presiding.

In attendance: Commissioners, Senator John Heinz; Representatives Edward Feighan and Christopher H. Smith; Ambassadors Richard Schifter from the Department of State and Samuel G. Wise, from CSCE.

OPENING STATEMENT BY CHAIRMAN DENNIS DeCONCINI

Chairman DECONCINI. The Commission on Security and Cooperation in Europe will come to order. I'd like to welcome our distinguished witnesses and guests to the Helsinki Commission hearing on psychiatric practices in the Soviet Union.

The timing of today's hearing coincides with the release of the report issued by the U.S. Psychiatric delegation, which traveled to the Soviet Union last February to examine and diagnose a number of current and former psychiatric patients.

Today's hearings will focus on three main questions. First, what are the main differences between the practice of psychiatry in the Soviet Union and in the West?

Second, what is the overall state of psychiatry in the Soviet Union today, and has it improved significantly to warrant that country's membership status again in the World Psychiatric Association?

And, third, what progress has been made in resolving the cases of those who were considered political prisoners but were being held in psychiatric hospitals at the time the Vienna Concluding Document was signed?

In the view of this Senator, the report which has been issued by the U.S. psychiatric team, can make a very valuable contribution in providing an initial framework by which to continue this productive dialogue with Soviet authorities and doctors.

The U.S. delegation should be commended for producing a detailed and forthright document which is replete with solid recommendations for improvement in Soviet psychiatric practice. I also want to go on the record with high praise for the dedication of the people who traveled to the Soviet Union and those who were in-

volved in preparing for this very unique experience and exchange with the Soviet Union.

In addition, it should be noted that the Soviets have submitted a response to the report, which is also available. They acknowledge the need for some of the improvements suggested by the U.S. team. This is a welcome development. In my view, continuation of this dialogue should be encouraged at the highest levels.

As positive as the potential for substantive cooperation is, however, we must bear in mind that, as the U.S. delegation states, "serious problems" still exist.

To help us examine these views, we are pleased to welcome representatives from the U.S. psychiatric delegation, the Department of State and, particularly, the Bureau of Human Rights and Humanitarian Affairs, headed by Assistant Secretary Richard Schifter, who conducted the difficult negotiations which brought this important initiative about. We will hear from the Ambassador, who is a member of this Commission, in just a moment.

Mr. William Farrand, Senior Deputy Assistant Secretary at the Bureau of Human Rights, was head of the delegation in the Soviet Union and had the immense task of coordinating the many complex aspects of this difficult endeavor.

We are privileged to have Dr. Loren Roth, the leader of the medical contingency of the delegation. Dr. Roth is Vice Chairman of the Department of Psychiatry at the University of Pittsburgh School of Medicine and was formerly Chairman of the American Psychiatric Association Council on Psychiatry and the Law.

It should be noted that the American Psychiatric Association provided invaluable expertise and advice in preparing the U.S. delegation for this trip.

Joining Dr. Roth is Dr. Darrel Regier, who was the senior representative on the delegation from the National Institutes of Health. He is the Director of the Division of Clinical Research at NIMH.

We are also pleased to welcome Dr. Peter Reddaway who is a professor of political science and international affairs at the Institute of Sino-Soviet Studies at George Washington University and, although not a psychiatrist himself, Dr. Reddaway, a member of the U.S. delegation, has studied psychiatric abuse in the Soviet Union and is co-author of the book "Russia's Political Hospitals."

And we are pleased to welcome Dr. Robert van Voren, who is General Secretary and founding member of the International Association on the Political Use of Psychiatry.

Dr. van Voren is also not a psychiatrist, but has studied the problem of psychiatric abuse in the Soviet Union extensively and has authored and edited several books on the subject. Dr. van Voren has recently returned from Moscow, where he met with members of the Soviet Independent Psychiatric Association.

I will yield at this time to Senator Heinz for any opening remarks that he might have.

STATEMENT BY SENATOR JOHN HEINZ FROM PENNSYLVANIA

Senator HEINZ. Mr. Chairman, thank you very much. I want to commend you, Mr. Chairman, for having assembled a particularly

fine group of witnesses. And I'm delighted that Ambassador Schifter is here as well.

You quite rightly make note, Mr. Chairman, that this group has had as a great concern the issue of Soviet psychiatry. It has been one of the most troubling human rights abuses that we have documented and seen behind the Iron Curtain.

I suppose it is troubling to many of us because there is a special revulsion about using medical science to achieve the ends of political repression and intimidation.

The distinguished witnesses to whom I referred here today have been extremely vigilant in documenting these types of abuses. And, of course, their views today are of great interest to us all.

May I say that I am very concerned that we not move hastily in readmitting the Soviet Union to the civilized fold in terms of psychiatric practices. Particularly as a layman, there is a complexity to this subject and a special evil to the abuses that occurred in the special psychiatric hospitals of the Soviet Union. I believe that these factors obligate us to be most careful and particularly exacting in changing our position on Soviet psychiatry.

The complexity of the issue requires, I might add, the expertise of the kinds of witnesses we have here today.

What I hope we achieve, what we get out of this and what we certainly need, is to establish a standard. I hope it is a high standard that takes into account not only those complexities, but does so in a way that we make clear what the prerequisite is for any acceptance of Soviet psychiatry as ethical and consistent with universal human rights. That standard has to be a clear one.

While it would seem that there are some apparently encouraging changes taking place in the Soviet Union, nevertheless, from what I have seen of the delegation's findings, I wouldn't be able to conclude that the Soviets have earned what you might call "absolution" under any standard, at least one that I would support.

And I do believe that the pressure, the attention, the contact, the visitations must continue and that, in the meantime, we must holdoff on any effort giving Soviet psychiatry a clean bill of health.

I certainly do welcome the views of these witnesses on how to set an appropriate standard and how current Soviet practice might measure up to such a standard.

Thank you, Mr. Chairman.

Chairman DECONCINI. Thank you, Senator.

Now, we will hear from the Congressman from Ohio, Mr. Feighan.

STATEMENT BY REPRESENTATIVE EDWARD FEIGHAN FROM OHIO

Representative FEIGHAN. I want to commend you, Mr. Chairman, for calling this session on Soviet Psychiatric Practices, a very important issue. I also want to thank our distinguished panel who will be giving their testimony this afternoon, not only for their presence here, but for their dedication to this issue.

As Senator Heinz has said, it is clear that the Soviets have made some important efforts in recent months to improve their psychiatric practices. But I think it is also compellingly clear from the sum-

mary of the report which this panel has submitted to us today that there are still very fundamental problems that remain.

I look forward not only to hearing the testimony from our witnesses today, but also to the opportunity to work over the next several months and years, if necessary, with members of this panel to ensure that the changes that must take place, do take place.

Thank you, Mr. Chairman.

Chairman DECONCINI. Thank you, Congressman.

We will now take any opening remarks from Secretary Schifter that you may have.

STATEMENT BY SECRETARY RICHARD SCHIFTER FROM THE STATE DEPARTMENT

Secretary SCHIFTER. Thank you, Mr. Chairman. I do have a few opening remarks, largely to explain just how we got to where we now are, namely the testimony of the representatives of the delegation.

Mr. Chairman, the years from 1964 until the arrival of Perestroika have come to be known in the Soviet Union as the "period of stagnation." One of the most shocking human rights violations, as we have already discussed, associated with that period, is the practice which has appropriately been labeled "abuse of psychiatry."

In an earlier period, the time of the terror regime of Joseph Stalin, the commitment of a political prisoner to a psychiatric institution was, oddly enough, an act of mercy; it could save such a prisoner from almost certain death in a labor camp.

It was only in the post-Stalin era, after the concept of so-called "Socialist legality" had replaced Stalin's system of mass detention and executions, that the organs of repression searched and found a new method for terrorizing political dissidents. That new method was the commitment of perfectly sane persons to institutions for the mentally ill.

Reports of the abuse of psychiatry first raised significant public concern in the West in the early 1970's. Credit for calling worldwide attention to the shocking mistreatment of political dissidents should go to Sidney Bloch and Peter Reddaway, who is with us here today, who in 1977 published in Britain a book entitled "How Soviet Psychiatry is Used to Suppress Dissent," fully exposing the Soviet practices of enlisting psychiatrists in a truly frightening system of suppression.

In the United States, the American Psychiatric Association, similarly, spoke out for the cause of medical ethics and against the misuse of their profession by those who had made the healing profession their calling.

The APA took the lead in calling the attention of the World Psychiatric Association to Soviet psychiatric abuse.

More recently, Ellen Mercer, as Director of International Affairs of the APA, saw to it that the reputation and the prestige of the American Psychiatric Association would continue to be brought to bear on this critical issue.

And in the Soviet Union, the truly courageous Dr. Anatoly Koryagin wrote his forceful exposition of the manner in which the practice of psychiatry was misused in the Soviet Union in the serv-

ice of a repressive state system. He had to pay for his courage with 5 years of incarceration in the GULAG.

These private advocates of human rights were in 1981 joined by the U.S. Government, which decided to raise the issue of Soviet abuse of psychiatry in the U.N. human rights fora.

We raised the question first in the Third Committee of the U.N. General Assembly and thereafter repeatedly at the U.N. Human Rights Commission.

We were convinced at that time that if we continue to publicize abuse of psychiatry, once change came to the Soviet Union, this abhorrent practice would be among the first to be ended.

Significant change regarding respect for human rights finally came to the Soviet Union in 1987. And it was in August of that year that we heard the first official statement suggesting reform in the administration of Soviet psychiatric hospitals.

The announcement was that the so-called "special psychiatric hospitals" were to be transferred from the jurisdiction of the Ministry of the Interior to the Ministry of Health.

Shortly thereafter, in private conversations with Soviet officials, one was able to infer that Soviet officials then recognized that something had, indeed, been terribly wrong with the process of involuntary commitment to Soviet psychiatric, particularly special psychiatric, hospitals.

As the Soviet Government increasingly came to focus on such human rights concerns and began in 1987 to effect improvements, our talks with the Soviets on those issues moved from monologues to dialogues.

As part of the new dialogue, we presented lists of persons who, in our view, had been committed to psychiatric hospitals for political reasons. In December 1987, we were for the first time provided with answers to some of the questions posed by us regarding questionable psychiatric commitments.

Specifically, in giving us the names of political prisoners released from jails or camps, our Soviet interlocutors interspersed that list with the names of persons released from psychiatric commitment.

They did not suggest that these patients had been miraculously cured. It was a clear concession that they had, indeed, been persons punished for their political and religious activities.

Our new human rights dialogue quickly moved from lists and cases to a discussion of broader institutional problems. One of the issues put on our agenda by mutual consent was forensic psychiatry.

To our suggestion that we encourage direct professional contacts between U.S. and U.S.S.R. psychiatrists, the Soviet Foreign Ministry responded that this could be done only on a government-to-government basis.

On the Soviet side, the Ministry of Health would be the appropriate contact point, we were told. We at the U.S. State Department turned for assistance to the American Psychiatric Association and, thereafter, the National Institute of Mental Health for professional guidance and expert advice. The cooperation which we received was truly outstanding.

The initial professional U.S.-U.S.S.R. contacts soon led to the suggestion of a visit by U.S. psychiatrists to the Soviet Union. That was negotiated by Dr. Roth, who is right here.

That visit, which took place in February and March 1989, was prepared with extraordinary care. It was an exceptionally important undertaking in the history of the psychiatric profession. It was equally important in the context of U.S.-U.S.S.R. relations.

Credit for the successful completion of this task belongs to. Dr. Lewis Judd, Director of the National Institute of Mental Health, who made the basic decisions which permitted the entire effort to go forward; to Dr. Darrel Regier, who skillfully supervised the preparatory work and made certain that there was adherence to the highest scientific standards; to Dr. Loren Roth of the University of Pittsburgh who, with vigor and persistence, negotiated the terms of the visit and led the professional team; and, last but not by any means least, Robert W. Farrand, the Senior Deputy Assistant Secretary of the State Department's Human Rights Bureau, who took charge of all the many parts of the enterprise which lay outside the scientific investigation and who thus made sure that all the pieces came appropriately together.

To Drs. Roth and Regier, we must also extend our thanks for diligently guiding the team which drafted the final report on the visit, in spite of their extremely busy schedules, and for having come up with a highly readable and informative document in less than 90 days, a major accomplishment given the complexity of the issue before them.

Let us hope that the document will prove to be a significant contribution to the psychiatric profession, to the cause of human rights, Perestroika, to better U.S.-U.S.S.R. relations, and thus to a more peaceful world order.

Thank you.

Chairman DECONCINI. Thank you, Mr. Secretary.

We will now hear from Mr. Farrand. You may proceed, please. If you have a full statement, we will put it in the record. If you would attempt to summarize that for us?

Mr. FARRAND. It's not that long, Mr. Chairman.

Chairman DECONCINI. Please proceed.

TESTIMONY OF WILLIAM FARRAND, DEPUTY ASSISTANT SECRETARY FOR HUMAN RIGHTS AND HUMANITARIAN AFFAIRS, U.S. STATE DEPARTMENT; LEADER OF U.S. DELEGATION

Mr. FARRAND. Mr. Chairman, I am pleased today to have an opportunity, in the company of my colleagues to the U.S. delegation to the Soviet Union which visited there in February and March for 2 weeks, to give you my impression of this what I considered unprecedented and, certainly, unique undertaking.

While virtually every professional member of the delegation had a hand in preparing the final report now before you, its main drafters were, as we have already heard, Dr. Darrel Regier of the National Institute of Mental Health, Dr. Loren Roth of the University of Pittsburgh; Prof. Richard Bonnie of the University of Virginia; and Dr. Harold Visotsky of Northwestern University in Chicago.

Drs. Roth and Regier are here at the table with me, and several other key contributors to the final report are also present in the hearing room today.

In view of their availability, I will not, in my brief statement, touch on the methodology and the procedures we sought to follow in carrying out this mission or on the medical or legal findings of the delegation's report.

I will instead confine my remarks to a few general observations about my own impressions of the exercise against the background of our overall relationship with the Soviet Union.

As to the delegation and the manner in which we conducted our work, let me first say that as a practitioner of various aspects of diplomacy with the Soviet Union, first as Consular Officer in Moscow from 1968 to 1970, later as Commercial Officer at our Embassy there from 1976 to 1978, and as Political Officer on the Soviet Desk in the Department of State from 1978 to 1980, and then finally in my current position since 1987, I thought that I had developed a certain "feel" for the Soviet system.

In this connection, if anybody had told me 10 years ago or, for that matter, even 5 years ago, that in 1989 I would be leading a delegation of American psychiatrists and other mental health and forensic specialists to the U.S.S.R. to interview actual patients and to visit psychiatric hospitals of our own choosing, where we would be allowed to talk with whomever we wished and even to ask orderlies to open locked doors on demand, I would have thought that person naive or lacking in critical powers. But that is exactly what happened.

Given my long association with Soviet affairs, I found each day's activities during my nearly 3 weeks this year in Moscow very revealing of the new mood and the "new thinking" in the U.S.S.R., which we all read and hear about, under Mr. Gorbachev.

The remarkable degree of access and openness to both current and former mental patients and to psychiatric hospitals was, for me, in a certain way, a sign of the times.

That said, several legitimate questions spring to mind. For example, given the enormity of the abuses charged to the Soviet psychiatric profession over the years and their natural desire to cover it up, some might wonder how the delegation's members could be sure that what they saw was real.

From the days of Potemkin villages under the czars, some could rightfully note that Soviet authorities are past masters at deception, at playing tricks, at pulling the wool over the eyes of others.

How could we know, some people would ask, whether the patients we interviewed were, in fact, the persons whom they themselves or whom the Soviet psychiatrists said they were?

How could we know whether the hospitals we visited hadn't been especially cleaned up, or "Potemkinized," as they say, just for the occasion? How could we be sure that other ruses and clever dodges hadn't been thrown in our path to give us a falsely positive impression?

Well, Mr. Chairman, the answer to such questions is that, in fact, you can never be sure that you haven't been misled in some way, especially when you're engaged in an undertaking like this, which exposes as many raw nerves as it did.

Let me simply assure the Commission that the team of professionals we brought together on this delegation were neither neophytes in their own field, nor, as in my case and that of several others, neophytes in dealing with the Soviet Union.

Each member of our delegation had read about and discussed extensively the failures of earlier groups of Western psychiatrists who had in the past traveled to the U.S.S.R. to look into charges of psychiatric abuse. We talked over their mistakes. We tried to learn from them.

Most importantly, we corrected the singular failure of those earlier groups to bring along their own interpreters from the West which, therefore, made it necessary for them to rely on Soviet interpreters. We brought along our own.

Thus, insofar as it was in our power to foresee and correct some of these problems, our delegation members went to Moscow with their eyes wide open.

Indeed, a leading domestic critic—that is, a leading Soviet critic who lives in the Soviet Union—of the Soviet psychiatric care system has acknowledged that this visit was "the first of its kind" and that in the past such visits, which were private, not governmental in nature, "were not," in his words, "as carefully organized and carried out."

I think a reading of the final report will show that the sorts of concerns I've mentioned here were taken fully into account by the delegation. In those cases where questions remained or where we were unsure of the data presented to us, the circumstances are documented in the body of the report.

Mr. Chairman, I can tell you that working closely with this fine group of medical, legal, and human rights professionals taught me one enduring lesson. I have learned that what a layman in medical matters might perceive on his or her first meeting with someone suspected of mental illness will more often than not come up with a misleading impression. I have come to understand that psychiatry is an exceptionally complex science, requiring the highest degree of training and judgment which must be honed over the years.

For this reason, the delegation's final report, in order to be credible, had to be researched and written by the psychiatrists and the forensic specialists on the delegation and not by the nonlegal or nonmental-nonmedical—participants, such as myself. I think that was a Freudian slip, if you will excuse the expression. I can't think of a better place for it.

I think the delegation has delivered a credible report. You will note in this regard that the Soviet Government has submitted its preliminary statements, which are printed separately, both in English and in the original Russian, for those who want to check the text against our informal translation. I have to stress that ours is an informal translation done under quick circumstances, so you will have the Russian to check it against.

In sum, while the Soviets do indeed take exception to some of our delegation's specific findings, on balance, in their words, they accept the report as an "important, valuable, and useful document" in addressing the current state of treatment practices in the Soviet Union and in assessing psychiatric changes now underway.

The Soviets have asked for an opportunity to submit more complete, final comments at some future point, and we have agreed to that. When such comments are received, we will issue them as we have their current commentary; that is, as an updated supplement to this final report, and will promptly submit their more complete statements and commentary to this Commission.

Finally, let me conclude by saying that I know that press and TV interest has been high ever since this endeavor began. But in view of our need to proceed carefully under the norms of medical ethics, to protect both the patients' right to privacy and our understanding with the Soviet Ministries of Foreign Affairs and Health that this undertaking would be carried out in strict accord with professional standards, we simply could not have responded earlier or more fully to press inquiries. The delegation needed this time to pore over the mass of evidence we had collected and to draw scientifically considered judgments from it. Until the delegation's report was prepared and submitted, we asked individual members to withhold public comment. That process is now completed and members of our group will be happy to take your questions and, later, to respond to the press.

Thank you, sir.

Representative FEIGHAN [presiding]. Thank you very much, Mr. Secretary.

Dr. Roth, if you would proceed?

TESTIMONY OF LOREN H. ROTH, M.D., M.P.H., PROFESSOR OF PSYCHIATRY, UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE; PSYCHIATRIC TEAM LEADER, U.S. DELEGATION

Dr. ROTH. Thank you. As the psychiatric team leader responsible for the overall planning and execution of the visit of the U.S. delegation to the Soviet Union, I am pleased to testify today.

This effort began more than 1 year ago as a professional interchange at a human rights round table between the U.S. State Department and the Soviet Ministry of Foreign Affairs.

Its scope was expanded considerably through the very generous support and guidance of the National Institute of Mental Health, thereby permitting a careful scientific look at recent changes in Soviet psychiatry. The American Psychiatric Association also played a very helpful role in enabling the visit.

As you have heard, it has long been alleged that political and religious dissidents in the Soviet Union have been systematically confined to psychiatric hospitals for other than medical reasons. This charge of abuse has many dimensions.

The practice of hospitalizing political and religious dissidents would be problematic from the human rights perspective, even if it were not predicated on intentional misdiagnosis.

To the extent that a governmental policy of repressing dissent has been operationalized through clinical practices and philosophies that are bent to the task, psychiatry has been misused.

The World Psychiatric Association condemned the Soviet Union for such practices in 1977. Six years later the Soviet All-Union Society of Neuropathologists and Psychiatrists resigned from the WPA rather than face almost certain expulsion.

However, Soviet psychiatric officials have repeatedly denied the charges of political abuse, as well as, in the past, denied access to the patients and psychiatric hospitals in question.

Recently there have been positive changes in Soviet psychiatry. Many hospitalized dissident patients have been released.

A new law passed in January 1988, is the first legislative enactment to regulate the process of involuntary civil hospitalization in that country. The 1988 statute also transfers jurisdiction over the Special Psychiatric Hospitals from the Ministry of Internal Affairs to the Ministry of Health.

In recent pronouncements, the Soviet Ministry of Health has also announced its intention to decrease the use of psychiatric hospitalization in the U.S.S.R. and to discharge patients from the psychiatric register. Available statistics suggest that some of these changes are taking place.

It was in this context, then, that the U.S. delegation visited the Soviet Union to, first, provide a more systematic and scientifically based foundation for assessing allegations of psychiatric abuse in the U.S.S.R. than was previously feasible; second, to assess recent changes in Soviet forensic psychiatry, including the laws governing involuntary hospitalization; and, third, to assess mechanisms now in place to prevent future problems of abuse from arising.

For the most part, the U.S.S.R. hosts complied with the terms of the agreement under which the visit was made, although the delegation did encounter significant procedural obstacles that hindered its time-limited task and that appeared to reflect some Soviet reluctance to provide full access to needed information.

There were problems in securing timely and complete access to the records, and some patients were discouraged by the Soviets from being interviewed. If the U.S. delegation had not been active in keeping track of the patients and if it had not had its own sources of information, a number of key cases would not have been interviewed.

While in the U.S.S.R., the delegation interviewed 15 hospitalized and 12 recently released persons, all but 2 of whom were drawn from its original list of 48 patients.

The original U.S. list of 48 hospitalized and released patients was drawn from master lists of possible and likely abuse cases assembled by the U.S. Department of State and the American Psychiatric Association, which reviewed lists from a number of human rights organizations, including those of Soviet human rights activists.

The findings of the delegation are summarized in our report. A previous draft was forwarded to the Soviet psychiatrists for their preliminary comments, which have just been received and which accompany the report.

Dr. Darrel Regier, the scientific director of the project, who is testifying today, will next present some other background to the visit as well as the results of the diagnostic findings.

Then I will briefly mention the conclusions with respect to legal handling and rights protections for patients. So I will turn this over to Dr. Regier, then, with your permission.

Representative FEIGHAN. Dr. Regier, you may proceed, please.

Dr. REGIER. Thank you very much.

Representative FEIGHAN. Thank you.

TESTIMONY OF DARREL A. REGIER, M.D., M.P.H., DIRECTOR, DIVISION OF CLINICAL RESEARCH, NATIONAL INSTITUTE OF MENTAL HEALTH; SCIENTIFIC DIRECTOR, U.S. DELEGATION

Dr. REGIER. Mr. Chairman, members of the Commission, I am pleased to testify in my role as the scientific director of this unique U.S. delegation to assess Soviet psychiatry.

Following a formal request in December 1988 from the Secretary of the State, Shultz, to Secretary of Health and Human Services, Dr. Bowen, the National Institute of Mental Health was authorized to provide professional and scientific consultation for a State Department examination of alleged human rights abuses involving Soviet psychiatric patients.

The Assistant Secretary of Health authorized Dr. Frederick Goodwin, the administrator of our parent agency, the Alcohol, Drug Abuse, and Mental Health Administration, and then Dr. Judd, as the Director of the National Institute of Mental Health, to approve the planning and logistical support for an objective and professionally credible examination of selected Soviet patients.

Dr. Roth, an expert in forensic psychiatry, was appointed by the State Department to serve as the overall psychiatric team leader for the delegation.

As Director of the Division of Clinical Research at the National Institute of Mental Health, I was asked to assemble a clinical team capable of applying rigorous research methods to assess the presence or absence of specific types of psychiatric disorder and to evaluate the appropriateness of treatment of these selected patients.

To accomplish this task, we selected standardized psychiatric interview instruments that incorporate internationally accepted diagnostic criteria and have a high level of scientific reliability.

These diagnostic instruments were then translated into Russian, and Russian-speaking U.S. psychiatrists, some of whom are with us today, were recruited and trained for their use with the Soviet patients.

With patient consent, interviews were videotaped and audiotaped for later clinical review. There was extensive review of all of the medical records.

There were interviews with the patients' relatives and friends and with Soviet psychiatrists in what proved often to be day-long examinations with some patients coming back for additional questioning the following day.

Provision was also made to collect urine specimens from the Soviet patients to screen for drugs that could affect their mental functioning.

This comprehensive approach enabled NIMH to assist the State Department in providing a more systematic and scientifically based foundation for assessing allegations of psychiatric abuse than was ever feasible before.

I would like then to summarize the results of our diagnostic and treatment assessments, and Dr. Roth will then address the final objectives relating to the legal issues.

Among the 15 currently hospitalized patients examined who were alleged dissidents—I should indicate, as Dr. Roth has mentioned, that there were a total of 48 patients that we sent to the Soviet Union in December 1988 for whom we wished to have the clinical records.

Of those, there were 37 hospitalized. And all of these were individuals that Mr. DeConcini mentioned as being of concern to this Commission. They were of concern to the Commission because some assessment of their clinical status needed to be made in keeping with the closing agreements of the Vienna Conference.

There remained after the submission of this list only 13 of the original 37 patients that were still in the hospital when we arrived in the Soviet Union.

We saw those 13 patients, plus we added another 2 hospitalized patients by mutual consent. And then we saw 12 discharged patients, who had been discharged over the previous 2 years. We had a total of 27 completed interviews.

Among the 15 hospitalized patients, who were alleged dissidents, the U.S. team found evidence of a severe psychotic or personality disorder in 10 of the patients, or two-thirds. These diagnoses generally corresponded with those of the Soviet psychiatrists.

Five of the hospitalized patients were found to have no mental disorder, according to international diagnostic criteria. A summary of the diagnostic findings is included in the delegation's report, which is being released today.

Of particular concern were the five patients for whom we found no psychiatric diagnosis, particularly one, who was admitted as recently as December 1988 with a diagnosis of schizophrenia following his involvement in an intense period of human rights political activity.

Because he was on the psychiatric register, which is an official list of all patients who have had treatment in the past, it had been possible to re-hospitalize him quickly without any legal hearing.

The U.S. delegation has now received confirmed reports, though, that this and three other of the five patients, for a total of four, have now been released.

The final hospitalized patient has been transferred from a special maximum security psychiatric hospital to an ordinary psychiatric hospital at this time.

Among the 12 released patients that we interviewed, the U.S. team found no evidence of any past or current mental disorder in 9. The remaining three had relatively mild symptoms that would not typically warrant involuntary hospitalization in the West.

The broad Soviet concept of mental disorder diagnosis, in general, and schizophrenia, in particular, was apparent in the medical records of these patients.

Schizophrenia or other psychotic disorders had been diagnosed in 24 of the 27 patients interviewed. It was impressive that Soviet psychiatrists, interviewing the same patients with the U.S. team, found only 9 such diagnoses, which closely matched the U.S. assessments.

For virtually all other patients, the Soviet psychiatrists retained some psychiatric diagnosis, but included some as patients who have a diagnosis "in remission."

The clinical practice that led to hospitalization in the past was not consistent with United States or Western standards. For example, a substantial number of individuals who were arrested for political activities were diagnosed as having a severe mental disorder on the basis of such symptoms as "delusions of reformism" or "anti-Soviet thoughts."

These symptoms, even in the absence of an apparent impairment, confusion, or illogical thinking in the patients' understanding of their behavior, often led to an involuntary hospitalization for schizophrenia.

Now, the second major area, besides diagnosis, that we addressed was that of psychiatric treatment. Medical records and the patient interviews provided evidence that relatively high doses of antipsychotic medication had been given to some patients who showed no evidence of psychosis. The medication had been used to treat the "delusions of reformism" or "anti-Soviet thoughts."

Also, Soviet psychiatrists have used sulfazine treatment, a painful treatment of no known therapeutic benefit in the West, ostensibly to enhance treatment responses to antipsychotic medication.

However, the severe pain, immobility, fever, and muscle necrosis produced by this medication, as well as the pattern of its use in 10 patients, suggested that it had been used for punitive purposes.

Other treatments, including insulin coma and atropine injections, were used for patients in whom we found no evidence of psychotic or affective, mood, disorders.

Next, a list of recommendations is included in the complete report relating to the benefits of narrowing the diagnostic criteria for mental disorders in the Soviet Union.

Consistent with the openness illustrated by this effort with the Soviets, which was truly remarkable, we applaud further international collaborative efforts in the area of diagnosis, particularly with the World Health Organization which supports participation in international field trials of a new set of diagnostic criteria contained in the international classification of diseases.

The United States is also participating in the field trial with the World Health Organization, with the National Institute of Mental Health direction, to look at this new international classification system.

The use of neuroleptic medications for non-psychotic symptoms and the use of sulfazine and atropine therapy are not consistent with Western psychiatric practice standards, and it was recommended that these should be reevaluated on the basis of clinical or preclinical research studies of treatment efficacy.

In the Soviet response, we were advised that the Ministry of Health has now proposed a ban on all future use of sulfazine and atropine therapy, which we think is certainly a very positive step on their part.

In summary, we are confident that this careful assessment of Soviet diagnosis and treatment will provide an objective database regarding the clinical status of these patients.

Judgments about the human rights implications of these findings, however, remain the responsibility of this Commission, the State Department, and other human rights groups.

We have received a generally positive response to the clinical findings and recommendations from the Soviet Union, and we will be happy to discuss these after the proceedings are completed.

The NIMH, however, does appreciate this unique opportunity to be of assistance to the State Department and the Commission as you carryout your respective human rights missions.

Chairman DECONCINI. Thank you very much.

And thank you, Mr. Feighan, for conducting the meeting.

We will now go to Mr. Reddaway.

Dr. REGIER. Excuse me. I believe that Dr. Roth needed to——

Chairman DECONCINI. I'm sorry.

Dr. REGIER [continuing]. address the findings after you stepped out, we mentioned that he was going to come back and address the legal issues.

Chairman DECONCINI. Very good. You did not finish, Dr. Roth?

Dr. ROTH. No. I was going to give you a small overview of the legal handling and rights protection findings.

Chairman DECONCINI. Yes. Please go ahead.

Dr. ROTH. Fine. Confirming information available to the West, the delegation found that almost all of the released patients had been hospitalized as a result of political or dissident behavior; for example, writing and distributing anti-Soviet literature, aiding nationalist aspirations or identity, political organizing, and so forth.

The extent of mental disorder manifested by these persons could not be used to sustain a finding in the United States of their being nonimputable, or not guilty by reason of insanity.

For patients still hospitalized, however, most of the offenses committed prior to hospitalization did not involve these type of dissident activities. Such behaviors did precede the hospitalizations, both criminal and civil, of some patients, indicating that the problem of misuse of psychiatric hospitalization in the U.S.S.R. to confine dissidents had not yet come to an end.

However, no patient examined by the U.S. delegation had been hospitalized within the past year as a consequence of arrest under the political articles. In other words, these were cases that had been there for a little while.

Persons examined also told the delegation that they were not accorded rights already specified in Soviet Codes of Legal Procedures; for example, to play a role in the process of investigation, to learn about the charges against them, to receive investigative and forensic reports, or to be present at their trial.

The delegation was critical of the broad concepts of "social dangerousness" contained in Soviet law that have contributed to the practice of hospitalizing nonmentally ill persons in the U.S.S.R. and has recommended that the Soviet Criminal Codes be revised to remove all prohibitions against expression of political or religious beliefs.

Concerning civil hospitalization, as Dr. Regier mentioned, the delegation did examine one nonmentally ill person who underwent civil hospitalization within the last 6 months, whose behavior was essentially political.

While acknowledging recent changes in Soviet law that might help to reduce the likelihood of future abuse, the delegation was not reassured that these changes will prevent future abuses and

has made a series of recommendations with respect to procedural protections.

Notwithstanding the partially implemented transfer of jurisdiction over the Special Psychiatric Hospitals from the Ministry of Interior to the Ministry of Health and the apparent goodwill of the administrators of the hospitals visited, these facilities continue to have many characteristics of psychiatric prisons.

Patients are denied basic rights, are apparently subject to punitive use of medication, and are fearful of retaliation if they complain about their treatment, about abusive conduct by the staff, or restrictive hospital rules. In brief, the transition to a more humane regime at the Special Psychiatric Hospitals has just begun.

Concerning removal of diagnoses, the delegation supports continued reevaluation of the medical indications for placing or retaining patients on the psychiatric register.

To prevent their psychiatric histories from stigmatizing persons who are not mentally ill, diagnoses should be removed to facilitate these persons' full reintegration into society.

Now, looking forward, the delegation recommends that the U.S. and U.S.S.R. initiate discussions to arrange the details of a visit by a Soviet delegation of psychiatrists and other experts to hospitals and forensic facilities in the United States, to arrange a follow-up visit to the Soviet Union by the U.S. delegation to allow the delegation to meet with patients interviewed on the prior visit, and to arrange ongoing collaborative exchanges and joint scientific studies recommended in the report.

Finally, the delegation recommends the formation of an international commission, including members from the U.S., the U.S.S.R., and other nations, to review alleged Soviet abuses—excuse me—to review alleged psychiatric abuses in any nation. And the Soviets do seem responsive to that suggestion.

In closing, I would like to take note of what I perceive to be a positive and helpful response to the report of the U.S. delegation by the Soviets. You have a copy of the Soviet response. This response does suggest that they are amenable to many of the recommendations contained in the U.S. report.

I would be pleased after the formal statements to answer any questions you may have. Thank you.

Chairman DECONCINI. Thank you, Dr. Roth.

I have some questions for some of you, but we will go ahead with the panel. Mr. Reddaway?

TESTIMONY OF PETER B. REDDAWAY, M.A., PROFESSOR OF POLITICAL SCIENCE AND INTERNATIONAL RELATIONS, INSTITUTE FOR SINO-SOVIET STUDIES GEORGE WASHINGTON UNIVERSITY; HOSPITAL SITE VISIT TEAM, U.S. DELEGATION

Mr. REDDAWAY. Thank you, Senator.

The current situation in Soviet psychiatry needs a surrealist of Kafka's skill to describe it. On the one hand, an increasing range of Soviet journals have, since last November, been forthrightly saying what Soviet dissidents and Western observers have said for 20 years; this is, that politically motivated abuse of psychiatry has

taken place in the U.S.S.R. on a large scale for decades, causing enormous human suffering.

On the other hand, the leaders of Soviet psychiatry put forward a completely different picture. Either they say or imply that no such abuse has ever occurred or, a slight variant, they say that a few accidental mistakes occurred in the past as a result of psychiatrists being overly cautious and producing, "hyperdiagnoses," but that now such mistakes cannot occur, thanks to new legislation and administrative reforms.

The leadership as a whole also continues three long-established practices: manipulating foreign psychiatric organizations and delegations, thwarting victims of abuse who seek psychiatric "rehabilitation" or justice through the courts, and trying to discredit domestic critics of these abuses.

Why does such a dualistic situation exist? For the simple reason, I believe, that since early 1987 the long-standing leaders of Soviet psychiatry have been fighting to preserve their power in the epoch of perestroika, or restructuring.

In most fields, reform is well underway. And many, if not all, of the old leaders have been retired, disgraced, or even jailed. In psychiatry, however, even though perestroika has been needed for reasons of foreign as well as domestic policy, the leaders are still hanging on.

These leaders know that if they were to allow serious reform, it would soon sweep them away. For this reason, reform in Soviet psychiatry has, to date, been limited in declared intent and even more limited in practice.

As regards the system of political abuse, its most visible manifestation, hospitalized dissidents whose cases are known in the West, has now been largely removed by the convenient device of suddenly declaring them cured and releasing them.

But the system's infrastructure remains in place, and we also know, from new information as it arrives, that some dissidents previously unknown abroad remain interned, and also that new internments are sporadically occurring.

Just as important, if a repressive leader were to replace Mr. Gorbachev and/or if a crackdown on reformers and dissidents of the type recently seen in China were to take place, developments which could occur in the next few years, then the system of psychiatric abuse could again start "processing" large numbers of victims without difficulty.

The U.S. psychiatric delegation gained insight into this system, thanks to receiving very considerably more access than previous delegations to patients, records, and institutions, but this will not make the system inoperative.

Since last summer a dozen or so articles in the Soviet press have written frankly about problems of abuse. Two weeks ago, on June 28, a classic case was described in the Government paper "Izvestiya." Nothing was previously known in the West about the victim, Yu. I. Sobolev, a former director of a timber yard, even though he has been hospitalized three times for dissent and his psychiatric interments have totaled 1½ years.

Although diagnosed as a psychotic with a "depressive-paranoid syndrome," he was found by the hospital and by the reporter to be normal.

The origins of the third internment were described with unusual candor by a deputy police chief 3 weeks before the elections to the Congress of People's Deputies last March,

> I was phoned by the First Secretary of the Nikolayevka District Party Committee, V. A. Panasenko, who said that at a candidate's election meeting Sobolev had been putting forward some sort of undesirable ideas.
>
> He said that Sobolev must be taken out of circulation. I phoned the psychiatrist V. F. Kamalov and explained the situation. He said he'd write an order for hospitalization.

Now, the reporter writes, Dr. Kamalov,

> Admits that he consigned to compulsory treatment in a mental hospital, a man who was not on the psychiatric register and whom he had never even set eyes on.

The most significant aspect of the case is the casual, routine way in which the hospitalization took place, at a time when officials had long been telling foreigners in private that such practices had stopped and also, coincidentally, when the U.S. delegation was in the Soviet Union. Observers already knew this was not true because news of a score of new internments over the last year had reached the West.

However, the victims in these cases had soon been discharged and had not been hospitalized through the criminal commitment process. It was therefore possible to believe that these hospitalizations might be local aberrations which would soon come to an end.

The Sobolev case, however, tends to confirm my suspicion that whatever secret instructions have been issued by Moscow to local authorities probably tell them: (a) to avoid criminal commitments in political cases; and (b) what to do if news of a local case of civil commitment leaks out, namely to get the individual released.

In other words, the motivation of such instructions is probably not to eliminate new cases of political abuse altogether, but to prevent its continuing, more infrequent use from causing problems for the U.S.S.R.'s foreign policy.

Another recent article in the Soviet press by Leonid Zagalsky in "Literaturnaya gazeta," June 28, is notable for its wide range and also for being the first to call for the resignation of three long-standing top executives of the system of political abuse: Drs. Georgy Morozov, Marat Vartanyan, and Alexander Churkin.

Dr. Churkin, the Chief Psychiatrist of the Ministry of Health, played a prominent role in the negotiations for, and conduct of, the recent U.S. psychiatric delegation.

In May of this year, he was invited by a group of American psychiatrists who did not trouble to look into his credentials to take part as an honored guest in the annual convention of the American Psychiatric Association in San Francisco. I shall say more about him and his colleagues below.

Zagalsky's article starts by examining the primitive material conditions, the dirt and demoralized atmosphere of Soviet mental hospitals, including those of Moscow's Serbski Institute for General and Forensic Psychiatry.

He describes how he accompanied an earlier American group to this institute and how they were carefully kept away from the de-

pressing sight of the wards, a sight which was, "not suitable for weak-nerved Americans. Only hardened Soviets could "endure such a spectacle."

The foreign criticism which led in 1983 to the U.S.S.R.'s resignation from the World Psychiatric Association, or WPA, was, in Zagalsky's view, fully justified. He seems to doubt whether the Soviet application to be readmitted will be approved at the WPA's Congress in Athens this October.

Certainly the thrust of his article suggests a belief that Soviet psychiatry has not yet earned readmission.

In this connection, he looks at the records of Churkin, Morozov, and Vartanyan, who hold in their hands "all the reins" of Soviet psychiatry. Churkin has been Chief Psychiatrist of the Ministry of Health for more than a decade, a term which makes clear "what role he played in dissident cases all these years."

Churkin, Morozov, and Vartanyan are servile officials, Zagalsky goes on,

> . . . people of the past. A vast quantity of facts about the abuse of psychiatry and its use for political purposes testifies incontrovertibly to the guilt of the leaders of this branch of medicine. It was with their connivance that healthy people were sent to mental hospitals, their reputations and whole lives ineradicably damaged.

"If," Zagalsky continues,

> . . . even one human life has been wrecked through one's own fault, one should resign. This is what people do in societies claiming to be civilized, if their actions have been discredited in the view of public opinion.

In this case, however,

> No one has resigned.

The claim is that, "psychiatry has changed so much that now no one will ever be put in a mental hospital without strict criteria being met." Again, Zagalsky's comment is skeptical. "We'll wait and see."

He ends his article by recounting several cases of the Sobolev type and with an analysis of how the mental health legislation of 1988 has been undermined by Ministry of Health directives.

The result, in his opinion, is that, "as in the past," nobody is guaranteed against arbitrary hospitalization and excruciating treatment with sulfazine.

Evidence of the untrustworthiness of the leaders of Soviet psychiatry also came to light during the U.S. delegation's recent trip to the U.S.S.R. Some of this is recorded in our report.

Particularly striking to me was the physical ejection from our hotel, in Kazan, of two young psychiatrists who had just started telling members of our group what things had been concealed from us during our visit to the Kazan Special Psychiatric Hospital, or SPH. They were ejected by the Deputy Director of the SPH, Dr. Idrisov.

Also striking were the statements by a number of patients in the Kazan and Chernyakhovsk SPHs that they had been warned they would be punished if they spoke to us negatively about the SPHs.

More recently, the deviousness and furtiveness which prevented frank, straightforward discussion of the issues with the official Soviet psychiatrists whom we met, showed up in the new U.S.S.R. Supreme Soviet, when Minister of Health Evgeny Chazov was

asked whether psychiatric abuse had been ended. This occurred the day before yesterday.

Chazov avoided a direct reply, but said that the 1988 legislation provided a guarantee against abuses, that the SPHs had been transferred from the Ministry of Internal Affairs to the Ministry of Health, and that recent psychiatric delegations from abroad had not been able to name a single person currently held in mental hospitals because of his beliefs.

The truculent disingenuousness of this reply did not surprise me since Dr. Chazov is closely associated with Dr. Vartanyan, has worked in the Ministry for nearly 20 years, and almost certainly believes that if the lid is finally blown off Soviet psychiatry, he will risk disgrace along with Vartanyan and the others. But it is still worth noting the deviousness of his reply.

First, the 1988 legislation and related Ministry directives have been shown by Soviet lawyers, as well as by Zagalsky and foreign commentators, to be seriously defective. Our report reaches the same conclusion.

Second, the transfer of the SPHs is only a very partial one. As our report makes clear, the transfer allows the MVD to continue to have a strong influence over the SPHs since it still employs, directly or indirectly, the key personnel in them.

Third, in referring to foreign psychiatric delegations, Chazov deceptively omitted to mention, first, that our delegation had in March found no reason why five hospitalized dissidents whom it examined should be confined, as Dr. Regier has mentioned; second, that we had found other patients in hospitals we visited whose cases were at least partly political or religious and who appeared, if only on short acquaintance, not to need confinement; and, third, that medically unjustified commitments of dissidents were still occurring, such as that of Sobolev, which had just been reported by "Izvestiya," the main organ of the Government to which Chazov himself belongs.

It may be helpful if I add to the U.S. delegation's report a few personal observations about mental institutions which could not be included in the report for lack of space.

First, as regards conditions in the two SPHs we visited, these have, indeed, to all appearances, changed very little as yet. The prospects for change seemed to me better at Chernyakhovsk than at Kazan, partly because the former's administration was making considerable progress in reducing its hospital population, but more especially because the administrators were newly promoted and, in contrast to Kazan's, less burdened by a need to justify past practices.

As noted above, the transfer of the SPHs from the MVD to the Ministry of Health, or MoH, does not seem very real or significant on the ground. The doctors are still MVD officers, even though they receive MoH directives, and the guard units are still wholly under the MVD. At Chernyakhovsk the MVD officer refused me permission to look inside a watchtower.

Also it seems that the KGB's presence in the SPHs has not disappeared. In Kazan, I interviewed the head of the so-called "Special Department," the official who has traditionally been the KGB's representative in each SPH.

Maj. Nikolai Vdovenko became flustered when I asked him if he worked for the KGB, but after looking at the head of the SPH, Lt. Col. Rail Valitov, they both said no, he reported only to Valitov. Moreover, he had never worked for the KGB.

However, as the only photograph on the wall of his office was one of Felix Dzerzhinsky, the founder of the KGB, I suspect that he and Valitov were lying.

The problem of brutality in the SPHs is addressed in our report. I would only like to add that at Chernyakhovsk, many inmates complained about the cruelty of Dr. Dmitry Podryachikov, with whom I talked twice at some length.

These conversations inclined me to believe that he did indeed regularly intimidate patients by shouting at them and sometimes having them severely beaten by orderlies.

I met one patient who, according to him and several other witnesses, had almost died from a beating administered on Dr. Podryachikov's orders and in his presence. Later two of the doctors who were his colleagues indicated that they shared my impression of him.

As regards the 1988 laws, these had been in force for a year, but 90 percent of the SPH inmates I met didn't know anything of their existence and no one knew their provisions.

Some of the SPH psychiatrists admitted not knowing about them and none that I met was eager to discuss them. At Kazan a display board that I saw headed "New Developments in Legislation" carried no material newer than 1983.

Turning briefly to the ordinary psychiatric hospitals, or OPHs, I would like to note only that while the Vilnius OPH we visited was much superior to the Kaunas OPH, even the Kaunas one was better than, to judge from several recent reports, the average OPH in less advanced parts of the U.S.S.R. than Lithuania.

How much change has occurred, then, in the area of forensic psychiatry, and what prospects exist for further change?

My view, as a result of our trip, is that a timid start has been made to reform, but it has been imposed on a resistant, hostile, and defensive Ministry of Health by politicians who have been able, at times, to mobilize certain journalists and lawyers in their support.

The prospects for further change seem uncertain and, as long as Vartanyan, Morozov, Chazov, Churkin, and Nikolai Zharikov, the new head of the All-Union Society of Psychiatrists, remain the key figures, extremely limited.

In sum, perhaps 10 percent of what is needed has been done, but no breakthrough has yet occurred, and currently there is no strong momentum which might produce one. The Establishment is just holding the line and is fighting hard, mostly with success.

In my view, though, if the individuals listed were to be removed or transferred to professorships, this would be the key development which could easily lead to real reform, perestroika, taking place in Soviet psychiatry, as has already occurred in other spheres of Soviet life.

In those circumstances, I believe that political abuse would soon be ended and authoritatively condemned, and at least some safeguards against its reemergence might be developed.

Finally, dissidents like Alexander Podrabinek have for the last year taken the view that Soviet readmission to the WPA would be premature. This view has now been argued by the Kiev Psychiatrist Semyon Gluzman in a letter to Western colleagues, which is appended to this testimony.

The bottom line of his eloquent, philosophical, and constructive appeal is this,

I don't understand how one can accept back into the WPA people who tortured in the past and do not acknowledge it today.

The people the WPA would get back would be,

. . . not the thousands of ordinary Soviet psychiatrists who saw it all and understood it all but were afraid to protest, but, rather, the false scientists and hangmen, the stained ones, those without a conscience, the incompetent ones.

Mr. Chairman, I concur with Dr. Gluzman's views.

Chairman DECONCINI. Thank you, Dr. Reddaway, for a very profound statement.

And we're very pleased that Dr. van Voren is with us today from Holland. We appreciate your travel to be here. Dr. van Voren is the General Secretary and a founding member of the International Association on the Political Use of Psychiatry. And we're pleased to hear from you, Doctor.

Dr. VAN VOREN. Mr. Chairman, before I read my statement, I would like to ask if I could submit a number of papers for the record?

Chairman DECONCINI. Indeed, Dr. van Voren, we will submit your papers for the record. And, without objection, they will appear.

I have to advise the panel that I have to leave to go to an Appropriations Committee meeting to allocate the 302(b) allocations. I'm going to ask Congressman Smith if he will take the chair in just about 5 minutes.

Thank you. Please proceed.

TESTIMONY OF DR. ROBERT VAN VOREN, GENERAL SECRETARY, FOUNDING MEMBER, INTERNATIONAL ASSOCIATION ON THE POLITICAL USE OF PSYCHIATRY; DIRECTOR, BUKOVSKY FOUNDATION/SECOND WORLD CENTER

Dr. VAN VOREN. Mr. Chairman, the moment you have chosen for these hearings on Soviet political abuse of psychiatry is very appropriate. In the coming months events will determine whether this political abuse will continue for years to come or whether there is actually a chance that this means of repression will be terminated.

Much depends on the decision of the World Psychiatric Association, the WPA, which will have its World Congress in Athens in October this year. During that World Congress, the General Assembly of the WPA will vote on an application of the Soviet All-Union Society of Psychiatrists and Narcologists to rejoin the WPA.

As you know, the Soviet All-Union Society was forced to withdraw from the WPA in 1983 for its continuing abuse of psychiatry for political purposes. During the General Assembly of the WPA in Vienna in July of that very same year, 1983, a resolution was passed stating that the WPA would welcome the return of the Soviet All-Union Society, "but, would expect sincere cooperation

and concrete evidence beforehand of amelioration of the political abuse of psychiatry in the Soviet Union."

Now, 6 years later, the Soviets are doing their utmost to assure their return to this international body.

Sure enough, there have been positive developments since the Vienna World Congress, in particular during the past 3 years. For instance, Dr. Anatoly Koryagin, the well-known and brave Kharkov psychiatrist who actively opposed the practice of political abuse of psychiatry and cruelly suffered for it, was released and allowed to emigrate. Further, many victims of political psychiatry were released in the U.S.S.R.

The Soviet press criticized psychiatric practices in their own country and new regulations were adopted, which are supposed to guarantee the rights of mental patients in the U.S.S.R.

But there were also negative developments. While many victims were released, many new cases became known and it became clear that political psychiatry and psychiatric malpractice were more widespread than we ever thought.

Our association still receives information on political use of psychiatry and the internment of people who are, in fact, mentally healthy. For instance, recently we received a report from the Independent Psychiatric Association of the U.S.S.R. on the work of their diagnostical center.

Of the 44 former patients examined by them, more than half had either no signs of mental illness at all or had only minor personality disorders that needed no psychiatric treatment.

These people were not only victims of psychiatric abuse, but they are still outcasts in Soviet society as they are still on the psychiatric register.

Despite criticism in the Soviet press, neither the authorities nor Soviet psychiatric leaders acknowledged that people were interned in psychiatric clinics for purely political reasons.

While a few psychiatrists were dismissed or demoted because of corruption, the same leadership still controls Soviet psychiatry. And their leadership is the stumbling block for any real change.

The new regulations on psychiatric help are hardly an improvement, which is even acknowledged by Soviet lawyers, but not by Soviet psychiatrists.

It is our considered opinion that the changes in Soviet psychiatry are not yet of a fundamental nature and do not guarantee a discontinuation of the political abuse of psychiatry.

The structure of political psychiatry, a policy initiated and supported by the Soviet authorities, still remains intact.

Soviet psychiatrists vehemently deny that there has been, or still is, any systematic abuse. They try to minimize the problem by talking about "just a few incidental diagnostical mistakes in the past" or by a so-called acknowledgement of incidental "hyperdiagnosis," which means that the patients were, in fact, mentally ill, but should have had less treatment than they actually got.

However, patients who, according to them, were "hyperdiagnosed," were found by Western psychiatrists to show no signs of mental illness whatsoever.

There are many reasons why this view, namely that the political abuse was not more than some incidental diagnostical mistakes by individual psychiatrists, is pure nonsense.

The well-known dissident psychiatrist Dr. Anatoly Koryagin recently listed seven reasons, and I will name a few. For instance, many dissenters were diagnosed by the most experienced psychiatrists, among them professors from the Serbski Institute, who perfectly knew that their patients were sane.

Second, the percentage of mentally ill among political prisoners is unbelievably high. In the 1960's and the 1970's, almost one-third of all those arrested for political reasons were interned in psychiatric hospitals. In some cases even a collective diagnosis was made, which is scientifically just impossible.

Also the ways in which a mentally ill political prisoner could ensure a discontinuation of the treatment are quite extraordinary. Regularly the KGB proposed release from a hospital in exchange for a renunciation of earlier views or a promise not to continue human rights activities.

Patients who recanted suddenly found themselves to be mentally healthy again and were sometimes used for radio or television broadcasts.

It is our strong belief that a return of the All-Union Society of Psychiatrists of the U.S.S.R. to the WPA under these circumstances would not be helpful in cleansing Soviet psychiatry. In fact, it would hamper such a process.

The Soviet psychiatric leadership is putting on an all-out drive for readmittance. If the World Psychiatric Association allows them to return unconditionally, their position will be strengthened and little will change.

However, if the World Psychiatric Association puts firm conditions to the return of the All-Union Society of Psychiatrists, the present leaders would be replaced by more ethical ones, psychiatrists of a younger generation, sick and tired of these abusive practices and the effects that they have on their scientific contacts with the outside world.

Such a process is very likely under the current circumstances. All spheres of Soviet life have been under strong attack in the Soviet Union itself. Their leaders have been replaced by younger and less corrupt ones, except in Soviet psychiatry.

Postponement of readmission until the next World Congress of the WPA, to be held in 3 or 6 years from now, would put a strong enough pressure on the Soviets to realize effective changes desired.

During a recent trip to the Soviet Union, I saw this point of view supported by almost all of the people I met, including leading Soviet psychiatrists and well-known activists against political use of psychiatry.

In fact, there is a unique agreement of opinion regarding this issue. A return of the All-Union Society of Psychiatrists to the WPA would prevent a major and very necessary overhaul in Soviet psychiatry.

Our association deplores the fact that it has taken the American delegation so long to publish its report. We are relieved that now the report on this mission is released for distribution, an end has

come to this long period of uncertainty, especially for those who were examined by the delegation.

We hope that they will soon be notified of the outcome of the examination, especially because reports from the U.S.S.R. have shown utter anxiety on their part.

We would like to congratulate the U.S. psychiatric delegation for the work they have done in the U.S.S.R. Their conclusions are an important addition to the already existing extensive evidence that psychiatry in the Soviet Union has been abused for political purposes, is still abused to that end, and that much will have to be done to guarantee that these abuses will not be continued in future.

Unfortunately, the 4 months silence on the part of the American delegation allowed the Soviets to pretend that nothing is wrong, that the Americans found no evidence of political abuse of psychiatry, and that, therefore, they should be allowed to rejoin the WPA.

This was stated on many occasions by, for instance, Dr. Pyotr Morozov, the Secretary for International Affairs of the All-Union Society, in France.

Equally unfortunate is the fact that the leadership of the WPA has decided not to wait for the publication of this report. The hurried and unconstitutional return of the Soviet All-Union Society to the WPA will very much hamper any reforms in this field.

That decision was unnecessary, untimely, and shortsighted. We are sorry that the delay in the publication proved to be unwillingly helpful to both the current WPA leadership and to the Soviet All-Union Society.

Thank you.

Representative SMITH [presiding]. Thank you very much, Doctor.

At this point I think we can proceed with questions. I have a few opening questions, and then I will yield to the distinguished Senator, Mr. Heinz. Dr. Roth, let me begin with you.

One of the most disturbing elements which I believe the report illustrates is the list of profound differences between the way psychiatry is approached in the U.S.S.R. and in the West.

For example, I would like to read an excerpt from page 59 of your report, which quotes a high official at one of the Special Psychiatric Hospitals.

> Freedom in society has moved to freedom in psychiatry.
> Crossing the border is a sign of mental illness, as is distributing religious leaflets, but now we feel that these people can be treated in ordinary psychiatric hospitals.

Could you tell us how you respond to that kind of statement and whether or not you feel that a person holding such views can be considered a professional medical colleague?

Dr. ROTH. I did not have the opportunity to personally speak with this high official in the Special Psychiatric Hospital. This was a report from one of the members, one of the psychiatrists, of the hospital team, which we have cited in this report as an example of the kind of thinking that we would find, I would say, very problematic and have difficulty agreeing with.

The statement, I suppose, reflects a sense of movement and the sense of reevaluation of what constitutes dangerousness. In that sense, it is a positive statement and, in that sense, it parallels to some extent the change in criminal law.

Now, it does not seem to reflect any change in thinking about the science and symptoms of mental illness.

The problem is you cannot make an automatic equivalent statement. We saw people, for example, who did cross borders, who were mentally ill, and where there was a relationship between crossing the border and that person's mental illness.

Now, undoubtedly, there are many cases that are not of that type. The problem then becomes one of some automatic equivalent of a particular form of behavior with mental illness. There are many signs and symptoms of mental illness, depending upon its motivation.

The statement is obviously quite problematic, and I would say, the way it stands, it is simply not reasonable.

Representative SMITH. Would any other members of the panel like to address that statement?

[No response.]

Dr. Regier, could you describe for us the examination techniques used by the American psychiatrists?

Dr. REGIER. Yes. We used some standardized psychiatric interviews that incorporate in them questions that allow us to see if the patient meets the criteria for a given psychiatric diagnosis.

It's a form of cross-examination of the patient so we can assess the presence of symptoms, the severity of those symptoms, the duration of those symptoms, and the level of impairment that is associated with them.

The symptoms are then clustered into diagnoses. And a person has to meet a given level of symptom severity and impairment before they qualify for a diagnosis of a mental disorder.

These instruments have been tested on many patients in international studies. They have an agreed utility in identifying the presence or absence of a specific type of mental disorder.

And we were very careful in selecting these so that there would be replicability of our findings. If somebody else wished to go back and examine these patients, we feel quite confident that they would be able to find the same symptoms.

And if their criteria of a diagnosis agreed with the international criteria that we used, we feel that they would have a diagnosis of a mental disorder or they would be free of a diagnosis of a mental disorder.

Representative SMITH. Could you tell us why the Soviets seem to have within their case load approximately 75 percent of their diagnoses lead to schizophrenia, or the Soviets say that schizophrenia is the problem, as opposed to about 25 percent of our own case load in this country?

Dr. REGIER. Well, that is, of course, one of the major questions we had. When 24 of the 27 patients were identified as having schizophrenia and/or another severe psychotic disorder in the medical record and only 9 were diagnosed as having schizophrenia by the psychiatrists who joined us at the time of our examination, it's clear that there is a difference between the diagnostic criteria used at the time of admission of these patients and the criteria that were being used by the psychiatrists at this time.

We examined these patients carefully. We were interested in seeing if the pattern over the course of the patients' medical history fit with an early diagnosis of schizophrenia.

If somebody was hospitalized 19 years ago, for example, and had a diagnosis of schizophrenia at that time, we tried to assess whether it was reasonable that a person would look like they do at this point in time if they had had that diagnosis then.

And, of course, there are periodic reexaminations of these people over that period of time that are documented in the medical record as well. And we looked to see if the symptoms that were reported there were consistent with the picture that we saw now.

We also listened to what the patients said and whether or not they indicated any presence of a thought disorder or illogical thinking.

So basically what we can only conclude is that a much broader concept of psychosis, including some symptoms that we would not consider to be of a psychotic nature, such as this idea of delusions of reformism and the like, were being used in the past to make these diagnoses of a psychosis.

Representative SMITH. I noticed that the response from the Soviets is titled a "Preliminary" report. Are we expecting a more detailed report in the near future, Mr. Farrand?

Mr. FARRAND. We told the Soviets when we were there in November that they would have an opportunity to comment on the report before we went public with it. And we went back later and reiterated that to them.

They have asked now—they have stated that they didn't have time in the 3 weeks between the time the report got out and the time of the hearings to get their commentary in in final form. We had to have it a week in advance of the hearings. There was a month from the time they got it, that they had an opportunity to get their comments in.

They have labeled their comments "Preliminary," and they have asked for a chance to submit more detailed comments, and we have agreed to that.

Representative SMITH. OK. What are the plans to followup on the treatment of released psychiatric prisoners? Are there any plans? It is my understanding that some of the people who have been released—at least one that I know of and I am sure there are many others— have been recommitted. Dr. Roth?

Dr. ROTH. Well, there are certain steps we have taken. We are concerned about the continued treatment and protection of these patients. First of all, on many occasions, that idea was communicated quite directly during the interview process itself.

Second, you will see that in the section of the report labeled "Prospect," there is a recommendation or, really, a plan to reexamine some of these patients on a future trip to the Soviet Union.

Now, I can't tell you what the formal nature of that trip will be or who will be on it, but I think we have pretty clearly communicated that there is an expectation that these very same patients will be seen again in the future by some American psychiatrists in order to ensure that these patients are protected.

Next, we do maintain a rather constant vigilance about the outcome of these patients as best we can. And in this example, Dr. van

Voren is very helpful and publishes periodic information about these patients.

When Mr. Farrand and I were in the Soviet Union, we specifically asked about these patients, and we talked with Soviet human rights activists about any maloccurrences that might be taking place.

We have asked for a status report on each one of these patients. We asked for follow-up information on all of those who were normal, in our view, and still in hospitals to see if they were going to be discharged.

So in various ways we have tried to indicate quite directly that we are concerned about these patients and we intend to follow their status.

Cochairman HOYER. Doctor, excuse me.

And, if I might, Senator, I know you have been here 1½ hours and you need to go.

Senator HEINZ. That was the savings and loan conference with the House Banking people last night.

Cochairman HOYER. Yes. I want to apologize and, if I can break in, make a few comments, if I can, Senator.

I feel very badly that I have not been able to attend this hearing. We are in the labor health markup. Now, I know that none of you are interested in the labor health markup of the Appropriations Bill, but that is where I have been.

The reason I wanted to break in, I wanted to make a comment, particularly to NIMH, but to all of those including the American Psychiatric Association, who have been involved in this effort.

I had the opportunity of being on the plane the other day and getting a preview of the tentative translation of the response from the Soviets, which, for those of you who have not dealt with the Soviets, perhaps, on a 1-on-1 basis over an extended period of time, was, indeed, an extraordinary response in terms of its positive nature. The continued willingness of authorities in the Soviet Union for self-criticism, is radically new in terms of the last 24 to 36 months. Dr. Judd and I discussed this very briefly on the plane.

But, Dr. Roth, I want to say that we are going to put a little bit of language, frankly, in the labor health bill that we are marking up now in saying that we appreciate what the NIMH and other federal participants have done.

Assistant Secretary Schifter and I have worked very closely together. I'm going to be reviewing the record because I am one of those, I suppose, on the Commission who has been most involved in this, most interested in it. Obviously, Senator Heinz has been here for a period of time but I haven't been able to attend the hearing that I pressed for because one of the eminencies of America, known as Bill Natcher, schedules things when he pleases to schedule them. And I am pleased at that myself.

But I want to say to all of you, those of you who have reviewed this procedure, those of you who participated in this procedure, in my opinion, you have significantly advanced the cause of the human rights agenda of the Helsinki Final Act by your efforts and contribution.

We are now in a period of votes on the floor, which is the only reason that I got out of the markup. Bill Natcher let us out of the

door. But I wanted to come here and say that. I am going to have to leave soon because we will have another vote.

But I want you all to know that I intend to review the entire transcript so that every word you said will not at least be lost to this member because I intend to review every word of testimony that has been offered here and every written document that has been offered.

Dr. Reddaway has testified many times before, is one of the experts in the country, in the world really, is one of the sovietologists that we rely on most heavily. I want to review your testimony and observations with respect to this.

But I feel very strongly that this has been a very, very positive effort, and I wanted to come over and say that. I will stay as long as I can until we have the next vote.

And, Senator Heinz, thank you very much for allowing me to give that interjection. Thank you.

Senator HEINZ. Congressman Hoyer, let me just say that I want to second your remark, not that you asked me to, about your deep involvement and interest not only in the general work of the Helsinki Commission, which you have chaired so ably over so many years, but, in particular, in the issue of Soviet abuse of psychiatry.

I think most of the members of the panel know about your involvement in that, and it is remarkable, and I commend you for it.

But I have to disagree with one thing you said, and that is that none of the people down there have much interest in what you're about to do back in your Appropriations Committee.

I suspect Dr. Regier has more than a passing interest in the NIMH appropriation.

Dr. REGIER. Dr. Judd has even more.

Secretary SCHIFTER. Dr. Judd is in the audience. He is the Director of the National Institute of Mental Health.

Cochairman HOYER. I promise I will return.

Senator HEINZ. So your work in other spheres does not go unappreciated. I just wanted you to know that.

I would like to ask just a few questions. I will be brief because I want Congressman Hoyer to have his opportunity. To get back to the issue I raised in my opening statement about under what terms and conditions there should be readmission of the Soviet Union by the World Psychiatric Association, my questions fall into two areas, one having to do with institutional and legal issues, and the other having to do with issues of medical practice.

Now, as I understand it, there is a law, as of January 1988, under which control of the special psychiatric hospitals is supposed to revert to the Health Ministry from the Interior Ministry.

But I am also advised that apparently this only is happening at a relatively low staff level. And this raises the question about whether we are ever going to be able to escape from the politicization of Soviet psychiatry?

And I want to start, at least, with Peter Reddaway with the question. Given the past political nature of Soviet psychiatry, in particular, what institutional changes would be adequate to ensure that medical, not political, considerations predominate in psychiatric practice in the Soviet Union?

And are there additional institutional realignments and legal changes that are necessary or, in the alternative, are you pessimistic? Do you suppose that psychiatry in the U.S.S.R. inevitably will be tainted by political considerations?

Do you want to tangle with that one, Peter?

Mr. REDDAWAY. I'm not completely pessimistic by any means. I, however, don't think that it is likely it would ever be completely changed, the situation, and that there would be a complete removal of politics because you will only get a chance of that if you have, first of all, good laws and, second, a real separation of powers, which the Soviets, at any rate, so far do not show signs of seriously moving towards.

But a number of individuals and groups have tried to make a checklist of conditions which would improve the situation and would be the sort of checklist they wanted to see fulfilled if the Soviets were to be readmitted to the World Psychiatric Association.

And I will mention those. first of all, a release of all known dissidents, religious, political, and other, from mental institutions; second, the psychiatric and also social rehabilitation of formerly interned dissidents—this is something which has virtually not started in the Soviet Union so far, and the authorities don't seem to be pushing it in anything more than a rather marginal way—third, the improvement of legislation so that there would be an effective and immediate right of appeal to a court, something that is not provided for satisfactorily by the present legislation.

Fourth, an effective monitoring system should be set up, which would be made up not only of doctors and lay people inside the Soviet Union, but would also have an international element to it.

And, finally, the view of most people who have made these checklists and of myself is that there is no hope whatever of making significant further advance until the present leaders of Soviet psychiatry are removed and discredited and there has been official condemnation—both by the psychiatric profession in the Soviet Union and by the political leaders—of the political abuse of psychiatry.

This did happen eventually in Soviet biology some 25 years ago, and it was only after that had happened that Soviet biology could really be brought back into the mainstream of world biology and all the evil effects of Lysenko and Lysenkoism could be removed from Soviet biology.

So I think maybe that's a partial answer to your question.

Senator HEINZ. Are any of you optimistic that prior to the issue of permanent readmission coming before the World Psychiatric Association, that there is any prospect of that taking place in Soviet psychiatry, on the latter point?

Mr. REDDAWAY. No. I think that checklist is an agenda which couldn't possibly be carried out in the months before October of this year.

Senator HEINZ. Let me ask some questions, and maybe I am going to focus on Dr. Roth for two reasons. One, he is an eminent psychiatrist. Second, he is from Pittsburgh, the most livable city in the United States and my hometown.

Dr. ROTH. Without a doubt.

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Senator HEINZ. We've got to keep plugging it at every opportunity, Dr. Roth.

Cochairman HOYER. So much for objectivity.

Senator HEINZ. It's a great thing to have.

Cochairman HOYER. Yes. Right.

Senator HEINZ. And you will learn.

Cochairman HOYER. Yes. Right.

Senator HEINZ. Is your view, given the fact that three times as many per capita diagnoses of schizophrenia are made in the Soviet Union as here, as I understand it, that there are just irreconcilable differences between the Soviet practice of psychiatric medicine and Western psychiatry that cannot be bridged?

And the second part of that question is, are those differences such that we will never be able to consider Soviet psychiatry normal and ethical? And if you wanted to elaborate, I might ask you further whether such differences are primarily based on political and institutional differences?

Dr. ROTH. Why don't I try my hand at the beginning of an answer and then turn some of it over to Dr. Regier, because of his expertise in diagnosis. I don't think that differences between psychiatrists around the world should ever be irreconcilable.

I think psychiatry is capable of objective analysis of the signs and symptoms of psychiatric disorders, that inevitably there are cultural influences on the interpretation of those disorders, but there is enough of a common language at this point in time that if psychiatrists from anywhere in the world can sit down together and have an honest discussion—and that has been part of the difficulty here—and have an honest discussion about what each one sees, that we can come to a more common diagnostic framework.

And Dr. Regier may want to say something about this in terms of even previous cross-national studies, and what have you.

So I am not feeling that there is some scientific barrier between American and Soviet psychiatry. Hopefully, there will not be, and that the progress will go in that direction. So that is my first answer.

The question of whether these differences are political or scientific, of course, is at the root and the difficulty of the present analysis. We have attempted in this report to make as an objective, scientific analysis of the practices as possible.

In other words, we did careful diagnosis, and we developed structured interviews which led to a recitation of the nature of the legal rights provided the patients or their failure to receive these rights. So we try to approach this in an objective way.

There are many more things that would have to be done in the future to get down more to the basis of what the fundamental causes of the phenomenon that we observed really are.

Senator HEINZ. So you're saying at this point you don't know how much of it is political and how much of it is not political?

Dr. ROTH. I really honestly don't know.

Senator HEINZ. All right.

Dr. ROTH. And you will see that there is a direct statement——

Senator HEINZ. That is very helpful. You're saying more work has to be done.

Dr. ROTH. There is a direct statement in one of our conclusions that we could not tell. We had no access to the investigative reports. We don't know legally what happened to these people and who detained them or why in great depth exactly because of documentation we do not have.

This was not a discussion with the KGB. We did not sit and discuss legal handling of patients. We sat with fellow professionals discussing psychiatric handling and discussing legal rights. This is the limitation of what we have done, and we have been forthright.

But there was no other way to approach it, in our view, at this time. So the point is. Let's go to the next step.

Senator HEINZ. Very well. And I gather, based on this, all of you would—if you were asked to advise the international psychiatric association, your advice would be not to readmit the Soviets this fall?

Mr. FARRAND. With one exception, Senator. As a government, we're not going to have a view on what a private organization does or does not do, such as the American Psychiatric Association. So I just——

Senator HEINZ. But, based on personal opinion, I gather there would be—maybe Mr. Farrand has the right to remain silent, giving his opinion. All of the U.S. citizens, even if they are in government, have the right to remain silent, and most of us frequently don't.

Dr. ROTH. Senator, excuse me. I feel the necessity to say something at this point because I do need to clarify that because we wished to get an objective view and not to have our report read as a necessary endorsement for entry into the WPA or a necessary criticism, our delegation has had the posture that we have no official position on the WPA period. And that is what I say to you psychiatrically.

The hope we have is that we have done our job objectively so that people like Dr. Reddaway and Dr. van Voren, other psychiatrists, Dr. Melvin Sabshin, who is sitting here——

Senator HEINZ. I take your point. It is a very important——

Dr. ROTH [continuing]. to figure out what they want to do with it.

Senator HEINZ [continuing]. point for you to emphasize, and I accept it wholeheartedly. But I think those of us who listen to your objective appraisal would come to the conclusion, objectively, that the Soviet Union has a long way to go and should not be readmitted under any circumstances at this time.

I want to turn this over to Steny because I know he is going to have a vote, and I've got another appointment. And, Mr. Chairman, I thank you.

Cochairman HOYER. Thank you.

Dr. Roth, I appreciate that answer as well that you gave to Senator Heinz. And, quite obviously, the purpose of your delegation was not to make that judgment, in any event, but to report back, as you said, as objectively as possible the status of psychiatric practice, particularly as it relates to certain people that you and your group had the opportunity to interface with.

Mr. Farrand, let me ask you a question, if I can. Secretaries Shultz, Schifter, Ridgway and I discussed, along with Ambassador

Zimmermann and many members of this Commission, including Senator DeConcini, most specifically, the Moscow Conference.

And there were certain conditions we had with respect to the Moscow Conference. One of those dealt with the resolution of cases. Now, there were a number of folks that were on a list, as you recall—and I am going to have to go in just about a second—whom we allege were political prisoners, in effect, not psychiatric patients.

Based upon your visit—and I have not had the opportunity to read the report yet because the Soviets got me, through Dr. Judd, their response a lot quicker than you did. That's not true. We've had the report.

But what is your observation with respect to political prisoners that may still be incarcerated in psychiatric hospitals?

Mr. FARRAND. Mr. Chairman, the report is quite explicit on this point. Of the 15 that were in the hospital, 5 were found not to have signs, as Dr. Regier said, of psychiatric disorder. Of those, today we understand that four have been released.

One has been upgraded from a harsh regime, Special Psychiatric Hospital to an ordinary psychiatric hospital. I don't want to speculate, but that is normally a step on the way out.

We are continuing our careful case review of all of these. We are keeping a careful count of all of those who have been released, those who are still in. We are going to be watching this very carefully.

And that in the run-up to the 1991 human rights conference in Moscow——

Cochairman HOYER. Yes. It's one of the three conferences on what is called a——

Mr. FARRAND. Correct. No, no.

Cochairman HOYER [continuing]. conference on the human dimension, as you know, CDH in French.

I apologize. One of the frustrating facts of this life is you simply cannot be in a number of places at one time. And I must return to vote.

Dr. Roth, again I want to thank you and all the members of your delegation, NIMH for their cooperation and participation, which was certainly voluntary and very much appreciated by me and, I think, by the Congress and by the people of the United States.

I am going to ask Ambassador Wise to continue to chair this. I think Congressman Smith will probably be able to come back after the vote. I don't know, frankly, where we stand at this point in time because I am just in and out.

But perhaps to conclude, Ambassador Wise, who, as you know, is not only our staff director, but has ambassadorial rank, was the number two individual in Vienna for the U.S. delegation, I am going to ask him to chair the balance of the hearing, and look forward to reviewing your comments and any other supplemental information that you have to submit.

So thank you very, very much for this contribution, which I think is significant.

Mr. Ambassador, if you will chair? And maybe Secretary Schifter has some questions.

Ambassador WISE [presiding]. Thank you very much, Mr. Chairman. Let me first ask Assistant Secretary Schifter if he has any comments or questions at this point.

Secretary SCHIFTER. I have a question and a comment. Mr. Reddaway, in your list of conditions regarding further developments, you put down quite a number of very useful markers that we need to keep in mind.

With regard to the first of these, as you heard from the conversations that we had, it appears that as for our list, we are down to one case.

If you have other cases, could you please submit those for the record and also for us to look at and work on?

Mr. REDDAWAY. I'd be happy to do that. As I mentioned in my testimony, new cases come in every now and again. And sometimes we don't know whether they've been released or not by the time the information comes in.

But I think the chances of, at any rate, a reasonable flow of information are now quite good because there are two unofficial organizations in the Soviet Union that are monitoring developments fairly closely.

One is the Independent Psychiatric Association, which is a sort of replacement for the Working Commission on the Use of Psychiatry for Political Purposes you referred to in your opening remarks. This has existed now for the last 4 months and is developing, in particular, a diagnostic service to help dissidents or people who are afraid they are going to be branded as dissidents to receive objective psychiatric evaluations, which they hope will give them extra defense against arbitrary hospitalization.

The other group is less well-known in the West as yet. It's called the Committee for Social Defense, which is concerned not with political dissidents, but, rather, with ordinary people who have ordinary social problems to do with housing or medical services, or whatever, who continue to be put in psychiatric hospitals, it appears, fairly frequently.

But these are at such a local level and usually the hospitalizations are so brief that the information about them doesn't reach the West or, if it does, it relates to the past, rather than the present, when it reaches us.

But links between that Committee and the West are now developing, and I think it is an important aspect that we need to focus on increasingly in the future.

It is in many ways just as severe an abuse of psychiatry as is the psychiatric internment of political dissidents. And it is so routinized in the Soviet Union, the use of psychiatry against unfortunate social cases, people with elementary housing problems, and so on, that it may in some ways be harder to root out in the Soviet Union than the internment of political dissidents.

Secretary SCHIFTER. Well, I think you are making a very important point and we need to distinguish here among the various problems that we may run into.

With regard to political commitments, as I say, as far as we can tell—and we have monitored the situation closely—we are down to one case. If you know of any others—this is basically my point—please let us know.

Separate and distinct from that is the other problem that you have adverted to. By all means, any data that you can furnish us on that subject will be helpful. We can take it up with the Soviet authorities.

Mr. REDDAWAY. I would like to say that very often it is not so clear cut. Some of the individuals we met in the Soviet special psychiatric hospitals recounted their cases to us.

And it was clear that in some of them, there was a very strong political or religious element to the case, and in some cases, one or two, this actually involved use of article 70, although most of those cases had been transferred to ordinary psychiatric hospitals just before we arrived.

But in other cases, there is no political article involved, but there is, nonetheless, a political or religious background to the case, which may, in fact, be the decisive element in the person having been put in a special psychiatric hospital.

To make a complete list of all those would be impossible. We simply found them by chance.

Secretary SCHIFTER. What I am saying is, I am not looking for a complete list.

Mr. REDDAWAY. Of course.

Secretary SCHIFTER. You tell us whatever cases you know of, and we'll see what we can find out about them.

Mr. REDDAWAY. Thank you very much.

Secretary SCHIFTER. The other point I would like to make is with regard to Mr. van Voren's statement concerning the time for release of the report. I would like to say something now on behalf of the persons who prepared that report.

In the first instance, let me make one point very, very clear. No Government other than the U.S. Government took the trouble to raise these issues in the way they were raised with the Soviet authorities.

No other Government was able to make the kind of arrangement and allocate the resources, the manpower to get the job done that was done by this particular team.

As far as this team is concerned, the report that was written is not a staff report. It was written by the principals. These people have a great many responsibilities.

As soon as they returnedfrom the Soviet Union, they had to go back to their other responsibilities, other duties. Nevertheless, they took the time that was necessary to coordinate with each other, to spend the energy and the effort to get the report prepared and to get it done within less than 3 months.

I want to say it was a remarkable job for which they deserve a great deal of credit, for all the extra work they did, the nights and weekends that they spent to get this job done. For that, they deserve thanks.

Dr. VAN VOREN. Well, maybe I——

Ambassador WISE. Thank you, Mr. Secretary.

Dr. VAN VOREN. Mr. Chairman?

Secretary SCHIFTER. I don't think it's necessary to discuss it any further. I just wanted to make this particular point in terms of a work done by this particular team in discharging its professional responsibilities.

It was outstanding. The fact that they got it out that quickly is to their credit.

Ambassador WISE. Thank you, Mr. Secretary.

Dr. VAN VOREN. Mr. Chairman, maybe I can first add something to the answer to the first question regarding the number of political prisoners in the psychiatric hospitals.

What I have here is a list prepared by the U.S.S.R. News Brief in Munich, dated the 26th of June 1989, with almost 40 cases of people still in psychiatric hospitals. A similar list is being held by our representative in Moscow, Mr. Alexander Podrabinek.

The number of people on this list vary from time to time, as people get released, and people get interned. And it's quite often difficult to get the information as people are often interned far away in the provinces and not, as in the past, in the big cities as well.

But on his list, there are also some 40 to 50 cases of people who are still inside in psychiatric hospitals and on whom he has information not older than 1 month.

Apart from that, he has lists of people about whom we just don't know where they are. One example on his list was a Mrs. Olga Nozhak, who had been interned in a psychiatric hospital in the fifties and disappeared.

She was seen in 1971 by the human rights activist Natalya Gorbanevskaya, who is now living in Paris. And we just didn't know where she was. Our representative now found out that she died in the late seventies in a psychiatric hospital.

Regarding the second statement, I very well understand the difficulties that the delegation had in preparing this report. We are very thankful for the work they have done, and I think our association has done everything it could in order to help them to carryout this work.

I only want to stress that the fact that it took 3 months to write this report, also had negative implications and that the Soviets very well made use of this.

Ambassador WISE. Thank you. Let me ask you one or two questions, Dr. van Voren, since this is really the first time we have heard from you after your original testimony.

Have you heard anything new about individuals who have been released since the U.S. delegation left the Soviet Union?

Dr. VAN VOREN. Well, that is the problem. As I understand, information has been received that except for one of the persons who was released right after the American delegation left, another three people have been released, and that of the five who were found to be mentally healthy, only one is still in a psychiatric hospital.

We have confirmation of one of the three. On Saturday, I contacted our representative in Moscow, and he still has no confirmation on the other two.

Mr. REDDAWAY. Could I add——

Ambassador WISE. Yes. Please.

Mr. REDDAWAY [continuing]. a word about one case that I happen to know about?

Ambassador WISE. Mr. Reddaway?

Mr. REDDAWAY. One of the 27 was Mr. Leonid Gromov, who was brought to the U.S. team to be examined in a condition where he was so heavily drugged that the U.S. team decided that they could not make a full and proper examination of him. And they expressed the wish to the Soviet side that this be made possible in the future.

Since he was sent back to the hospital he was in, in Ulyanovsk, many efforts by Mr. Podrabinek and his associates to contact him have been unavailing. He has been held in isolation there in that hospital and subject, apparently, to great pressure to cave in and admit that he's mentally ill.

For this purpose, his father has been pressed into service, to write a number of letters to organizations abroad, saying that his son really is mentally ill.

The mother, by contrast, has supported her son and takes a different view. But it is undoubtedly the case that he has been isolated since the Americans tried to examine him.

And individual supporters like Mr. Podrabinek have been unable to gain access to him. This is a disturbing case.

Ambassador WISE. Thank you.

Mr. Farrand, you have something?

Mr. FARRAND. I wonder, Mr. Ambassador, would the chair permit Prof. Bonnie from the University of Virginia to have a word? He was a co-drafter of the basic report. And he has asked if he could say a word.

Ambassador WISE. Well, all right, certainly. Is he seated here?

Mr. FARRAND. Yes.

Ambassador WISE. All right. Would somebody give him a place for a minute? I'm sure we——

Mr. FARRAND. Would that be permissible? Thank you, Mr. Chairman.

Ambassador WISE [continuing]. would find it interesting to get an additional statement. Thank you.

COMMENTS OF PROF. RICHARD BONNIE, PROFESSOR OF LAW FROM THE UNIVERSITY OF VIRGINIA

Mr. BONNIE. Another voice, at any rate. I realize the hour is late, and I won't go on at great length. I don't have prepared remarks, but there were four points that came up during the course of the testimony and the questions and answers that, at least for the record, I would like to comment on.

One is in connection with the conditions at the special psychiatric hospitals and, more generally, the ordinary hospitals as well. I think that some of the observations that Dr. Reddaway made are important ones and need to be taken into account.

The conditions in the special psychiatric hospitals are extremely depressing. The conclusions stated in the report regarding the legacy of punitive psychiatry deserve continuing attention by the Soviet Union.

My own view, frankly, is that the two special hospitals that we saw should be closed. I think that they are that bad. And it's impossible to imagine how they could be converted to humane and therapeutic facilities.

These comments are not necessarily criticisms, if you will, of the individual psychiatrists who are responsible for administering those hospitals. One of the most promising things, to me, even in light of these critical observations about conditions in these hospitals, was the extraordinary openness that we found among the administrators and the staff of these hospitals.

And it is this particular point that I would like to amend in terms of what Dr. Reddaway said. He did call attention to the fact that there were some limitations, including, for example, the fact that he wasn't permitted to go into the watchtower.

I would emphasize the other side of that. I think the access that we were given to these hospitals was extraordinary, even though the Soviets knew what we knew—that the conditions of these facilities are extremely oppressive, that this is part of the legacy of the past and that resources are inadequate, among other things.

They gave us complete access to these facilities. And, frankly, I guarantee you that they gave us access to those facilities in ways that we would never do in this country to visitors from another country.

I could go on at great length about that, but I think that their openness and their candor in dealing with us is to be commended. That in itself is an indication of change, and we shouldn't overlook it.

Second, with regard to the issue of diagnosis, it is natural that the expansiveness of Soviet diagnostic categories and, particularly, the use of a concept of schizophrenia at odds with accepted diagnostic practices in the West, would be particularly controversial and troubling in connection with political dissidents.

It is in this connection that I would like to emphasize and agree with the point that Peter Reddaway just made, which is that the implications of the diagnostic practices in the Soviet Union are broader than the problem of political abuse.

The breadth of the diagnostic categories and, particularly, the use of schizophrenia, was evident in the special hospitals, even to an untrained person like myself, when we interviewed the patients. Seventy percent of the patients, approximately, in these hospitals had been prosecuted for, and found not imputable for, violent offenses. So this was not offense-related. But, nonetheless, it was clear, both to the psychiatrists—and, of course, they did not conduct the structured psychiatric interviews that were done in the 27 cases—as well as to those of us who are not psychiatrically trained, that the broad concept of sluggish schizophrenia is a significant cause of the conflict between coercive psychiatry and human rights in the Soviet Union. And this problem is not limited to cases of political dissidents.

So, therefore, I think that whatever is done eventually to bring the Soviet psychiatry back into the world scientific and psychiatric community will benefit the rights of the individual Soviet citizen. And that's a point that should not be overlooked while we are thinking about what the Soviets need to do in order to be invited back into the World Psychiatric Association.

Third, this raises the question of conditions for readmission to the WPA. The issue of conditions encompasses, it seems, some con-

ditions relating to the termination of past abuse. About that, I have nothing to say relating to the lists of patients, and so on.

But other conditions that might be set for admission to the WPA—or for whatever other political and diplomatic purposes this information might be relevant—relate to the institutional changes that need to be put in place to prevent abuses in the future.

Some of those relate to personnel. Dr. Reddaway and Dr. van Voren have been quite eloquent in their insistence that certain people in the psychiatric establishment should no longer be in such positions. I have nothing to say about that either.

There is, however, a third set of conditions that has been mentioned that relates to legal changes. About this, I do have something to say. One condition that Dr. Reddaway mentioned relates to the civil commitment process.

It has repeatedly been pointed out, in our report and elsewhere, that the problem with the civil commitment process is the absence of a mechanism for independent review. And it has been noted that perhaps one way to solve this problem is to require judicial review very early in the process of hospitalization.

I would like to amend that point by emphasizing something that appears in the Soviet response to the Commission's report. In a system without separation of powers, where the local judges are not necessarily independent of the local political establishment, judicial reviews may not be the best mechanism for achieving independent reviews.

And to the extent that this is relevant to ongoing discussions with the Soviets, I would emphasize the additional suggestion—and I don't mean to say that this is an alternative suggestion, but the additional suggestion— that is made by the lawyers from the Institute of State and Law of the National Academy of Sciences in their response to the delegation's report.

They say that the oversight responsibility exercised by the Procuracy, the prosecutorial establishment in the Soviet Union, under the new law should be operationalized by requiring the "consent," as they put it, of the procurator for cases of involuntary hospitalization and, indeed, for involuntary examination as well.

It's not clear whether they're saying this consent should be provided in advance of the hospitalization or within, I assume, a short time thereafter. That would need to be discussed.

This is an extremely important suggestion because, as I understand the legal system in the Soviet Union, the risk of abuse would be more likely to be reduced if the Procuracy could be brought into this process and provide the independent review that is now absent.

There are other legal conditions that one might want to emphasize. It is important to focus on the process of urgent hospitalization, or civil commitment, because, as the report points out, as the cases of abuse through the criminal process have been reduced, the process of civil commitment, which has traditionally been a matter of psychiatric discretion, could become the source of continuing abuses. It is a less visible process and is subject, even at the moment, to less legal control. This is an extremely important point.

Even while emphasizing the need for further reform of the process of civil commitment, we should not overlook the risk of continu-

ing abuse in the criminal system. I would reinforce the Dr. Reddaway's point that situations of political abuse do not always involve prosecutions under the political articles.

We ought to emphasize that one of the most important changes that has already occurred in reducing the risk of political abuse is the repeal of article 190/1 and the narrowing of article 70. That is a point that we should not lose sight of, that that is perhaps the most important change that could be made. But notwithstanding this change, political abuses, broadly defined, can occur under other articles.

And, therefore, the criticisms that the delegation made of the criminal procedures, and the systematic violations of the rights of the individual in the criminal process, need to be taken into account. Also, some mechanism for protecting the rights of patients once they are in those hospitals is needed.

And—I will close on this—the Soviets have agreed that some statutory protection, some statutory articulation of a patient's bill of rights, is required. These patients have no legal rights at the present time.

It is important to recognize, in law, the rights of the patients to be free of unnecessary restrictions or violations of their freedoms that are not clinically justified.

The States of this country, as well as the international guidelines that have been adopted, provide patients' bills of rights. One should be adopted in the Soviet Union.

There then needs to be an independent institutional mechanism for monitoring the enforcement of those rights and for investigating violations. It is very promising that the Soviet response indicates that they are exploring the creation of an independent human rights commission— very similar to those established in the laws of our States, including the State of Virignia—that is independent of psychiatry and that would be responsible for monitoring the protection of these rights.

The Soviets seem to be moving in that direction. We should encourage them. That would be another important condition that we ought to be looking at.

Ambassador WISE. Thank you very much, Mr. Bonnie. They were very interesting observations and added to the wealth of information we've been treated to today.

It is getting late, and I do want to close. I have one final question to Dr. van Voren, and then I will turn to Assistant Secretary Schifter, if he has any remarks to make before closing.

My understanding is that you had a recent visit to the Soviet Union and you have met with Soviets concerned——

Dr. VAN VOREN. That is right.

Ambassador WISE. with the abuse of psychiatry.

Could you tell us their impressions of the visit of the U.S. psychiatric group to the Soviet Union? Did they have some impressions of that visit?

Dr. VAN VOREN. Well, the impressions, of course, were rather limited as they did not have the report. They did not have any paper regarding the final outcome of the delegation.

On the whole, for instance, our representative from Moscow, Mr. Podrabinek, had the feeling that the outcome of the report would

support the feelings he had had over the past 15 years as far as psychiatry is concerned, and for which he served 5½ years in camp, prison and exile.

The same accounts for other opponents against political abuse in psychiatry, like Dr. Semyon Gluzman.

There was worry that the report—that it took so long to write the report and that they had no idea what the final outcome was.

A third worry was that the people who were examined by the American delegation had no idea whether they were found to be mentally healthy or mentally ill, and they certainly wanted to know.

So, in general, yes, they were very supportive of the delegation because it was the first delegation of its kind with so many possibilities, but there were also some critical remarks regarding, for instance, the long time that it took to write the report.

Ambassador WISE. Thank you. I don't know. I'm not an expert at all on the length of time required to write such a report. However, I get the impression, listening to the testimony today, this was a very complicated undertaking and involving a number of individuals on our side, on the Soviet side, and the patients themselves.

So I am very pleased that we have gotten the report now and that we were able to hold this first public hearing on the subject.

I do have one final question. I'm not quite sure to whom to address it, but can you give us any idea, maybe Mr. Farrand, of what future activities may be planned in terms of U.S. psychiatrists and their Soviet counterparts?

Mr. FARRAND. Mr. Chairman, these issues are being looked at. It's premature right now, on the basis of what we've got out in front of us, to give you any definitive statement on that, but the issue is under discussion.

Maybe Ambassador Schifter could have a comment or two or Dr. Regier. But I think, on the basis of what we have in front of us, we have something to digest now and we've got to look possibly at some sort of visit by the Soviets to the United States.

Possibly the key thing to get going here is some sort of dialogue to educate the Soviets to the realities of psychiatric practice in the West.

Ambassador WISE. Assistant Secretary Schifter, would you——

Secretary SCHIFTER. Deputy Foreign Ministry Adamishin will be here before long, and this will certainly be one of the topics on the table at that time.

Ambassador WISE. Thank you.

Any other remarks? All right.

Dr. REGIER. Mr. Chairman, could I just ask one——

Ambassador WISE. Yes, sir.

Dr. REGIER [continuing]. clarification for the record? It is important that, in the area of psychiatric diagnosis, there was one statement that Mr. Reddaway made which needs clarification. The delegation is convinced that there was only one patient with no mental disorder who remains in the hospital. The name of one additional patient was mentioned by Mr. Reddaway, who raised the question about this patient's diagnosis.

Dr. Samuel Keith, who is in the audience, was responsible for examining this patient and determining the presence or absence of a mental disorder.

And although there have been some problems in terms of his medication, I don't want the impression left in the record that he didn't have a mental disorder, or that, in fact, there is more than one patient with no mental disorder that still remains in the hospital.

Ambassador WISE. Thank you.

Mr. REDDAWAY. Mr. Ambassador, could I——

Ambassador WISE. Yes. Mr. Reddaway?

Mr. REDDAWAY [continuing]. address that? It would perhaps be also useful for the record to point out that in the case of the other 10, it's, I believe, not the view of the American group that all those 10 need to be confined in psychiatric hospitals.

They may have some diagnosis, but they do not necessarily need to be confined in a special psychiatric hospitals.

And maybe while I have the floor, I could reply very briefly to the useful comments of Mr. Bonnie. My point that I tried to make in my testimony about the access that we had, I agree it was remarkable access. And I mentioned in my testimony it was unprecedented.

But we do have to bear in mind that all the evidence shows that it was imposed on the Ministry of Health by the Ministry of Foreign Affairs, presumably acting on the orders of the top Soviet leadership.

In other words, if there is a change in the nature of the Soviet leadership in the future, there is absolutely no certainty and, indeed, quite a large chance that such visits would not be possible in the future.

There was not, in other words, voluntary cooperation by the psychiatrists. They were ordered to cooperate with us, and they did cooperate, to quite a large extent.

And I think it's important to bear in mind also, with regard to the nature of their response to our report, that there is probably a very considerable tactical element in their response.

Both the Ministry of Health and the Ministry of Foreign Affairs would like the Soviets to be readmitted to the WPA. And in order to achieve that goal, it's desirable to appear to be very reasonable and reformist and open to criticism.

I am afraid that may be a somewhat deceptive response that they are wanting to give for tactical reasons. And we should retain a certain skepticism until we really see that reforms are, hopefully in time, gathering pace.

Ambassador WISE. Thank you very much.

I think this hearing has shown that the visit of the American psychiatrists to the Soviet Union has made a very useful contribution in a number of ways. First of all, it provided all of us, and particularly those who are specialists in this area, with a wealth of new information.

It has, obviously, benefited individual human beings. We have heard of cases of releases during and after the visit. We have reason to believe that the Soviet authorities are looking into their practices.

I've read the preliminary statements that the Soviet side provided. I found it very interesting in that they welcomed most, if not all, of the American suggestions. They took issue with certain points, but they at least expressed a determination to benefit from the American suggestions.

And I think also that the hearing has been, and the visit has been, useful in providing clarification of at least one category of political prisoners in the Soviet Union and in helping to eradicate that category.

I'm not saying that that has been done yet, but I think this visit has provided a very useful stimulus.

I think we are all very grateful to all of you who participated, and we look forward to the further ideas, observations that may come out subsequently and, as Mr. Farrand indicates, the possibility of some further cooperation in this area.

I now close this session of the Commission on Security and Cooperation in Europe.

[Whereupon, the foregoing hearing was concluded at 4:29 p.m.]

APPENDIX

United States Department of State

Washington, D.C. 20520

AUG 15 1989

Dear Senator DeConcini:

I am pleased to respond to the additional questions you pose in your letter of July 21 to Deputy Assistant Secretary Robert W. Farrand of the Department's Bureau of Human Rights and Humanitarian Affairs concerning the U.S. psychiatric delegation's visit to the USSR in March of this year.

I repeat your questions below for clarity and completeness and follow each with our response:

Question 1: Would you say at this point that the elimination of the category of political prisoners in psychiatric confinement, which formed part of U.S. agreement to the Moscow CDH Meeting, has been accomplished? If yes, please explain.

Reply: The purpose of the U.S. Psychiatric Delegation's two-week visit to the Soviet Union was to assess, insofar as possible, changes in Soviet policies, law and treatment practices in the field of forensic psychiatry. As part of this process, the delegation relied on a list of 48 persons alleged to have been involuntarily committed to Soviet psychiatric hospitals for political reasons as the basic population for in-depth psychiatric interviews.

This list of names included, at the time of the delegation's visit, our best knowledge of all the Soviet citizens who had been listed as wrongfully committed to psychiatric hospitals for other than medical reasons, i.e., who had reportedly run afoul of Soviet authorities

The Honorable
Dennis DeConcini,
Co-Chairman,
Commission on Security and Cooperation
in Europe.

on political or religious grounds. As noted during the CSCE Commission hearings July 12, the delegation found that of the 13 hospitalized mental patients who submitted to full psychiatric interviews, four showed no signs of mental illness. Of these four, three have since been released from hospital and one has been transferred from the special psychiatric hospital (SPH) in which he was being held to an ordinary psychiatric hospital (OPH), often the first step toward release. The Soviet authorities have also released from hospital since the delegation's departure from Moscow on March 12 two more patients whom the delegation found during their diagnostic interviews to have signs of mental disorder. Therefore, to the best of our knowledge, of the original 48 names, only eight remain in hospital (excluding three persons who refused to be interviewed and whose refusals were confirmed by the U.S. delegations), seven of whom were found by our delegation to have genuine signs of mental disorder, leaving one hospitalized person who in the Delegation's view should be released. We hope that Soviet authorities will review and reconsider this single remaining case.

We know of one person who, having been previously committed and released, was during the past year recommitted and then once again released. Though we cannot possibly keep tabs on all developments in the USSR, it is fair to say that we have not received any information as to any initial politically motivated commitment since April 1987.

In light of these considerations, the decision of our Government to attend the Moscow Conference on the Human Dimension in 1991 remains unaffected by the findings of the U.S. Psychiatric Delegation. Should the progress we have noted to date be slowed or reversed, however, that decision will be brought under immediate review.

Question 2: The report states that some potential examinees were taken off the originally submitted list on the basis of official Soviet responses concerning their fate. Did you have independent, non-government confirmation of the Soviet government's responses?

Reply: Soviet officials advised the U.S. delegation of the need to delete four names from the original list of 48 names because one person had emigrated to the United States, one person was unlocatable, one person had died in hospital and, finally, one person had been transferred to the prison from psychiatric hospital. As to the first of these, the U.S. delegation confirmed through the U.S.

Immigration and Naturalization Service that the patient in question had indeed entered the United States as an immigrant in October, 1988.

As regarded the second case, the delegation conceded that the information provided to the Soviets about the person in question had indeed been sketchy. On pursuing the matter further, the delegation learned that the individual's case is no longer considered active by the independent Western sources who had formerly proposed it. As to the third person's alleged death, the Soviets have been asked to provide a copy of his death certificate so that an assessment can be made of their claim. Finally, as to the fourth name dropped from the list, the Soviet Ministry of Foreign Affairs notified our Embassy in Moscow on February 8 that this person had been judged competent to stand trial and for that reason had been transferred to the Soviet prison system in 1987. The delegation was not able to verify this information independently, but the prisoner's name has not appeared on a list of disputed prisoners prepared with the help of independent sources both in the USSR and the West in May of this year.

As to those persons whom the Soviet Government advised had been released from psychiatric hospitals between the time of delivery of our list and the arrival of the delegation's advance team on February 26, we sought the assistance of human rights activists in the USSR to check on the accuracy of Soviet claims. Our non-governmental sources in the Soviet Union found no instance in which their information as to the released status of the former patients in question varied with that given to us by the Soviet Foreign Ministry.

Question 3: Are there any plans in place to monitor the fate of released psychiatric prisoners?

Reply: As we noted during testimony before the Commission testimony on July 12, the State Department, both through the U.S. Embassy in Moscow and during such follow-on visits by U.S. delegation participants as may be considered in future, will insure that the fate of released Soviet psychiatric patients is kept prominently on the agenda in discussions with the Ministries of Foreign Affairs and Health concerning the state of forensic psychiatric and related treatment practices in the USSR. As a first step in this direction, we point to

the request in the Delegation's final report (page 73) that the Soviet Government provide a status report on each of the patients the delegations interviewed, either in-hospital or released. Further, quoting from the Report: "The U.S. hospital team identified 20 patients whose placement and treatment were questionable, even if it was not clear that these were political cases. The names of these cases have been submitted to the U.S.S.R. The U.S. Delegation has requested follow-up information about the outcome of these cases." The Commission may be assured that the fate of released persons who were, or reported to be, wrongfully committed to Soviet psychiatric hospitals will be closely monitored by the United States Government.

I trust the foregoing will be helpful to you in completing the hearing record on the state of forensic psychiatry in the Soviet Union today.

Sincerely,

Janet G. Mullins
Assistant Secretary
Legislative Affairs

University of Pittsburgh
SCHOOL OF MEDICINE DEPARTMENT OF PSYCHIATRY
Office of the Vice Chairman

August 10, 1989

Dennis DeConcini, Chairman
Commission on Security and Cooperation in Europe

Steny H. Hoyer, Co-Chairman
Commission on Security and Cooperation in Europe
237 House Office Building Annex 2
Washington, DC 20515

Gentlemen:

This letter responds to your letter of July 21, 1989, thanking me for testifying before the Commission on Security and Cooperation in Europe regarding the procedures and findings of the U.S. psychiatric delegation that visited the Soviet Union in February-March 1989.

Your letter of July 21, 1989, asks me to respond to two additional questions. I have noted each question, followed by my answer.

1. Can mental illness be caused by large doses of certain medicines? Were you able to determine this through your examinations? Can you tell if a patient was mentally ill before he/she entered the hospital, particularly after long-term confinement?

Can mental illness be caused by large doses of certain medicines? In general, mental illness is not caused by the ingestion of medicines. However, certain medicines, when taken on an acute or chronic basis, can alter a patient's mental state and produce signs or symptoms of mental illness. For example, amphetamine ingestion over an extended period can cause a paranoid delusional syndrome which resembles schizophrenia in some respects. Other medications, such as the drug Inderal (which blocks sympathomimetic -- adrenalin-like action) used to treat high blood pressure, can cause depression. Medications such as hallucinogens (LSD) can cause toxic confusional states on an acute basis.

The delegation attempted to rule out the possibility that a patient's mental state was caused by medication ingestion by collecting urine samples from the people being interviewed. These were then frozen with dry ice and sent for analysis to the U.S. Our report indicates (page 25) that no unreported medications were detected in the samples.

One hospitalized patient (No. 7) was overmedicated with neuroleptics and anticholinergic drugs and was therefore unable to produce sufficient urine for the urinalysis. It is possible that this patient's mental state on the day he was examined was caused, in part, by the excessive medication he had been given. In particular, the

examining team was concerned about the patient's slowed mentation; they did not feel his psychotic symptoms were a result of this medication. They felt such medication should not be given at this level. The delegation suggested in its report (page 100) that "A followup examination [of this patient] by independent psychiatrists under more favorable conditions is recommended."

As for other patients diagnosed mentally ill, the delegation did not suspect on clinical or on other grounds that their illnesses had been induced by medication. I must add that single clinical determinations are not absolutely perfect. The delegation's examinations must be evaluated in light of the circumstances under which they were performed. We could not perform repeat examinations over time.

In general, the delegation does not believe that the mental illnesses that we observed were induced by past or present medication.

Can you tell if the patient was mentally ill before he/she entered the hospital, particularly after long-term confinement?

Given our methodology, this is a question that permits no definitive answer. In general, through questioning patients and review of records, we did attempt to determine when the patient's mental illness had begun. For those patients for whom we were able to interview friends or relatives, we also obtained confirmatory material about patients' past mental states. The interview instruments we used are considered to be more reliable with respect to the patient's recent rather than past history. This is generally the case with respect to clinical interviews.

In part, the answer to this question depends on obtaining complete records, a thorough record review, and the obtaining of confirmatory information from external sources.

It is of interest to the overall inquiry whether patients may have become mentally ill because of their confinement. While in no instance did the delegation conclude that this was the case, we cannot with complete certainty rule out the possibility. Nevertheless, based on our clinical examinations, we do not believe that this was the case.

Again we draw attention to Case No. 7, who was overmedicated on the day we examined him. The case material, known to the West, as well as our examination, suggests he may not have been properly treated, but our examination found indications of a clinical condition existing prior to his hospitalization.

A more thorough answer to this question awaits complete review of voluminous psychiatric records that require translation. Even then, a problem will persist in knowing whether the records are fully accurate and complete.

2. We understand that you were told in March that the Ministry of Health was planning to review the use of sulfazine, and report on its findings in May. Have you heard anything in this regard?

Judging from page 5 of the Preliminary Response by the Soviet psychiatrists to the report of the U.S. delegation, it appears that Soviet psychiatry is reevaluating the use of sulfazine. It is considering, or has already implemented, a ban on using this medication

in psychiatry. The specific wording in the Soviet response (page 5) is "The Soviet side accepts the critical comments regarding the use of sulfazine and of atropine comas. At the present time, the USSR Ministry of Public Health has developed guidelines for a ban on using these medicaments in psychiatry." The delegation has heard nothing more. It is possible that the guidelines for a ban on using sulfazine emerged from the Ministry of Health's reconsideration of that drug in May 1989.

I hope this additional information is of use. The delegation appreciates the support of the Commission on Security and Cooperation in Europe in carrying out its work.

Sincerely,

Loren H Roth M.D.

Loren H. Roth, MD, MPH
Professor and Vice Chairman
Department of Psychiatry
Director, Law & Psychiatry Program

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse and
Mental Health Administration
Rockville MD 20857

The Honorable Dennis DeConcini
Chairman, Commission on
Security and Cooperation in Europe
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your letter of July 21, also signed by Congressman Hoyer, regarding my testimony before the Commission on Security and Cooperation in Europe. I am pleased to respond to your request for additional information included in the two questions raised in your letter.

The first question related to why Soviet psychiatrists diagnosed as many as 75 percent of their patients as schizophrenics while American psychiatrists reached this diagnoses for approximately 25 percent of their patients.

It is important to note that the estimated 75 percent with diagnoses of schizophrenia was obtained from descriptions of the special hospitals visited at Kazan and Chernyakhovsk, as presented in Appendix E of the report. These facilities are forensic or prison psychiatric hospitals which receive persons judged not guilty by reason of insanity for violent crimes within the Soviet Union, as well as individuals who have been placed in such facilities in the past for political or religious offenses. The ordinary psychiatric hospitals, which included Vilnius and Kaunas, did not have such high rates of schizophrenia diagnoses. In fact, the Kaunas facility had approximately 54 percent of its beds devoted to alcohol and drug abuse treatment. These are hospitals which provide treatment for voluntary patients as well as those who may be committed without criminal convictions.

The rate of schizophrenia diagnoses in forensic psychiatric hospitals within the United States is actually quite close to the 75 percent reported for the two Soviet hospitals. In a recent publication of a National Institute of Mental Health (NIMH) study of mentally disordered offenders admitted to inpatient psychiatric services (Steadman et al. 1988), a diagnosis of schizophrenia was recorded for 80 percent of patients admitted as not guilty by reason of insanity and in 47 percent of those "incompetent to stand trial." In another NIMH study which looked at all organized U.S. mental health services, schizophrenia diagnoses were made in 22 percent of all patients under care in a single day in inpatient, outpatient, and partial care programs combined (Rosenstein et al. 1988).

The more significant issue is our finding the use of an overly broad definition of schizophrenia within the Soviet Union--a finding which is not unlike that found in the United States some 20 years ago. At that time, the high rate of schizophrenia diagnoses in the United States was contrasted with a much lower rate within England. A major research study (Cooper et al. 1972) clarified that the reasons for the discrepancy in diagnosis included an overly broad definition of schizophrenia in the United States compared to the more restricted definition in the United Kingdom. This study led to a tightening of diagnostic criteria within the U.S. Diagnostic and Statistical Manual (American Psychiatric Association 19[illegible] and more generally to the adoption of restrictive criteria in the Int[illegible]national Classification of Diseases, 10th Revision.

Although the overly broad diagnostic criteria may have hindered appropriate clinical care, there is no evidence that this clinical practice led to a problem of systematic political misuse of these diagnoses in the United States. However, the major issue in the U.S.S.R. was that the overly broad diagnoses of schizophrenia were used to encompass political and religious dissident behavior which facilitated hospitalization rather than necessitating a public trial for these charges. Although the rate of schizophrenia diagnoses is relatively low in all countries, including the U.S.S.R., the use of this diagnosis in the Soviet Union for inappropriate political reasons was the major concern of the psychiatric delegation.

The second question was, "In your opinion, could any of the events described in the report occur in the United States?" From the above comments, it is clear that an overly broad definition of schizophrenia has occurred in the United States in the past, a situation corrected as a result of international collaborative research studies which pointed out reasons for such discrepancies. With regard to the narrow question of "Could there be a systematic abuse of psychiatry for the purpose of suppressing political dissent," the answer is probably "no." The one case that is usually raised as an example of the misuse of psychiatry for political purposes is that of Ezra Pound during World War II. He was hospitalized at St. Elizabeths Hospital as mentally ill which prevented imprisonment or execution for his pro-Germany political views; there remains considerable doubt about his mental disorder diagnosis.

Although the answer to this question requires the expertise of a political scientist rather than a research psychiatrist, I will offer a few informal observations. Any systematic abuse requires the concerted efforts of a coordinated police effort, a psychiatric professional group that can be subjugated or coaxed into misusing its medical judgment, and a legal profession that is also willing to agree with a covert administration

policy. Given the balance of powers in the U.S. political system and the relative independence of the medical professions, I think that the convergence of all of these necessary elements in the United States would be unlikely.

I hope that this additional information will be helpful as you complete your record of the Helsinki Commission hearings. I am sending an identical response to Congressman Hoyer.

Sincerely yours,

Darrel A. Regier, M.D., M.P.H.
Director, Division of Clinical Research
National Institute of Mental Health

Enclosure:
List of references

cc:
Lewis L. Judd, M.D.

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COMMISSION ON
SECURITY AND COOPERATION IN EUROPE
237 HOUSE OFFICE BUILDING ANNEX 2
WASHINGTON, DC 20515
(202) 225-1901

July 21, 1989

Dr. Robert Van Voren, General Secretary
International Association on the Political Use of Psychiatry
PO Box 3754
1001 An Amsterdam, NETHERLANDS

Dear Dr. Van Voren:

Thank you for testifying recently before the Helsinki Commission regarding recent developments in Soviet psychiatric practice. Your presentation will be a valuable addition to the hearing record.

Due to time constraints and floor votes, there were several questions that members of the Commission did not have the opportunity to ask. Therefore, the Commission would appreciate your written response to the follow questions:

1. If there is any more recent information on the individuals still incarcerated or those released since the delegation left the Soviet Union?

2. Are you aware of any psychiatric groups in Europe that are considering a similar visit to the Soviet Union?

3. During the hearing, mention was made of one Yuri Sobolev, who was committed to a psychiatric institution on the orders of a local Party official and a psychiatrist who did not even examine the patient. This was originally reported in the Soviet press. How do you view such a situation? Do you think this example is typical of local officials opposing glasnost and perestroika?

If possible, we would like to receive your responses by August 14, so that they may be inserted into the published hearing record. If you have any questions, you or your office may contact John Finerty at 202-225-1901 (fax: 202-226-4522)

Again, we want to express our appreciation for your having shared with the Commission your insight on the issue of psychiatric abuse in the Soviet Union.

Sincerely,

Dennis DeConcini

DENNIS DeCONCINI
Chairman

Steny Hoyer

STENY H. HOYER
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INTERNATIONAL ASSOCIATION ON THE POLITICAL USE OF PSYCHIATRY

ASSOCIATION INTERNATIONALE CONTRE L'UTILISATION DE LA PSYCHIATRIE A DES FINS POLITIQUES

INTERNATIONALE VEREINIGUNG GEGEN DIE POLITISCHE VERWENDUNG DER PSYCHIATRIE

To the Chairmen of the
Commission on Security and Cooperation
in Europe
Mr.D. DeConcini and Mr.Mr.S.H.Hoyer
237 House Office Building Annex 2
Washington, DC 20515, USA

Amsterdam, August 3, 1989

Dear Mr. Chairmen,

Thank you very much for your letter of July 21, requesting a written answer to a number of questions regarding my testimony before your commission. I will answer them point by point.

1. Due to the fact that many of those who were examined by the US psychiatric delegation either live or are (or were) incarcerated in the provinces, far from Moscow, it is difficult to receive up-to-date information on their current status. However, our association has so far received the following information:

Alexandrov: According to former political prisoner Mustafa Dzhemilev, Alexandrov was harassed by local psychiatrists, who repeatedly visited him at home, creating the impression that he would be re-interned. Our Moscow representative, however, could not get this information confirmed.

Degtyryov: released from psychiatric hospital after US delegation left the USSR; now at home. His case has been closed.

Gromov: There have been reports that his father has been pressurized to write a statement to Western radio-stations, that they should leave his "mentally-ill son" in peace. However, one should note that the parents of Mr.Gromov are divorced and that Mr.Gromov is only supported by his mother.

Ilchenko: The day after the US delegation left the USSR, he was released. A letter from Ilchenko, received by IAPUP's Moscow representative, shows that release from the psychiatric hospital is not the end of his problems. Many former victims are harassed or not given the possibility to start a new life. Ilchenko has no place to stay, and the authorities have no intention of helping him:

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"...Things are going badly with me. I have no place to live. I lived in a hostel, from which I was thrown out. The local authorities even refuse to give me a place in a hostel for bachelors, in a room for several people. They answer, that with my illness I can't live in a hostel or that they don't have hostels. At the Presidium of the Supreme Soviet of the Ukraine Nikolai Filipovich Krikunov said, when I asked his help in order to get a place in a hostel: "Get out of here and don't come back, otherwise I'll call an ambulance. Your place is in an boarding house for chronically mentally ill."
I have had enough of this. The psychiatrists aroused in me a staunch aversion against the Party and its propaganda. I sent a statement to the Presidium of the Supreme Soviet of the USSR with the request to take away my citizenship."
"Maybe they'll shut me up once more in a psychiatric hospital and with neuroleptics teach me love for the USSR and respect for the Communist Party. But it is likely, that they will not even consider my statement and will not answer."

Korfidov: His parents were told that if their son had not been examined by the U.S. psychiatric delegation, he would have been released much earlier. Subsequent release confirmed.

Molokanov: was supposed to be transferred to a hospital in Central Asia. No confirmation and no news since.

2. It has come to our attention, that the secretary for international affairs of the Soviet All-Union Society of Psychiatrists, Dr. Pyotr Morozov, recently proposed a hospital tour in the Soviet Union by a French delegation. Then, he said, they will realize that there are no more political prisoners in these hospitals. However, it seems unlikely that a French delegation will embark on such a trip.
It is our understanding that the German Psychiatric Association has been made a similar offer and that they are considering accepting it. However, I doubt that their delegation will be similar to the one from the United States, even if they do decide to go to the USSR.

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3. The case of Mr. Yuri Sobolev is a clear-cut example of a continuation of Soviet abuse of psychiatry for political purposes. It is evident that, for more than a year now, the internment of political opponents in psychiatric hospitals is almost entirely limited to the provinces, and not in Special Psychiatric Hospitals. However, as no structural changes have occurred (which is also acknowledged in the Soviet press), we fear that this is more a matter of tactical moves in order to facilitate the return of the Soviets to the World Psychiatric Association, than a real change of policy. Surely, local authorities oppose glasnost and perestroika and continue the old policies, like abusing psychiatry for political purposes. However, if the central authorities in Moscow would have ordered them (and the local KGB) to stop interning political opponents in psychiatric hospitals, Mr.Sobolev and others would not have been interned.

I would like to thank you for inviting me to testify before your Commission and hope this information is of use to you.
With best wishes,
Sincerely yours,

Robert van Voren.

FACTS THAT PROVE THAT THE POLITICAL ABUSES IN THE USSR ARE NOT DIAGNOSTICAL MISTAKES OF INDIVIDUAL PSYCHIATRISTS

1. Dissidents were always examined by the most experienced psychiatrists, professors of the Serbski Institute;
2. The high percentage of "illness" among dissidents is ununderstandably high (only few were not subjected to a forensic psychiatric examination, in the 1960s and 1970s every third [prisoner] was sent to a psychiatric hospital;
3. The presence of an overwhelming quantity of the "delirium syndrom" in the diagnoses of victims of psychiatry;
4. There were cases of "collective" diagnoses (in 1987 four Armenian Hare Krishna followers were at the same time given the diagnosis "schizophrenia", the couple Kutyavin were interned and released at the same time;
5. The direct proposal by the doctors and the KGB officers to victims of punitive psychiatry to be released in exchange for a promise to discontinue the earlier social activity;
6. The use of "recanted" patients of psychiatry for broadcasts on radio and television;
7. The repetition of the same "mistakes" in relation to one and the same victim by different psychiatrists during a period of many years.

Dr. A.Koryagin (signed)

Факты,свидетельствующие против того,что злоупотребления психиатрией в СССР - диагностические ошибки отдельных психиатров.

1.Диссидентов смотрели всегда самые опытные психиатры,в ин-те им.Сербского-профессора.

2.Невообразимо высокий процент"заболеваемости"среди диссидентов(лишь единицы из них не подвергались судебно-психиатрической экспертизе,в 60-70-х годах каждый третий отправлялся в психобольницу)

3.Наличие в диагнозах жертв психиатрии в подавляющих случаях "бредового синдрома".

4.Случаи вынесения"коллективного" диагноза(В 1987г. четырём армянским кришнаитам,идущим по одному и тому же "делу", одновременно был установлен диагноз "шизофрения",супругов Кутявиных вместе госпитализировали и вместе выписали).

5.Прямое предложение врачей и сотрудников КГБ жертвам карательной психиатрии:выписка в обмен на отказ от прежнего социального поведения.

6.Использование "раскаявшихся" пациентов психиатрии для выступления по радио и телевидению.

7.Повторение той же самой "ошибки"по отношению к одному и тому же инакомыслящему различными психиатрами на протяжении многих лет.

А.Корягин

IPA

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Консультант по социально-политическим вопросам:

Александр П. Подрабинек

INDEPENDENT PSYCHIATRIC EXAMINATIONS

In the period of April 12 to June 6, 1989, the Independent Psychiatric Association of the USSR gave a psychiatric examination on an outpatient-basis to 44 people, who at various times fell victim to psychiatric arbitrariness for political, ideological, ethical, social-material, industrial and other reasons. All those examined were categorized in the following groups:

1. Mentally healthy 15.9 %

2. Mentally healthy, but with certain character and personality disorders (varieties of acccentuation) 38.6 %

3. Neuroses and borderline cases 20.5 %

4. Mentally ill (a variety of forms of delirium and other psychopathological products, certain forms of mental retardedness) 25.0 %

(signed)

Viktor Lanovoi,
President IPA

Oleg Ukhov,
leader of the
social reception,
member of the Council of the IPA.

НПА

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Консультант по социально-политическим вопросам:

Александр П. Подрабинек

LIST OF MENTALLY HEALTHY PEOPLE

WHO FELL VICTIM TO COMPULSORY PSYCHIATRIC MEASURES AND WHO ARE CURRENTLY SOCIALLY REPRESSED

1. ISAULOVA, Maria Nistirovna, born 1945.
354207 USSR, Sochi, pos.Dagomye, Batumskoe shosse 16-19 tel. 315032. On the psychiatric register since 1972, after a compulsory hospitalization in a psychiatric hospital in connection with her refusal to have intimat contact with the director of the sovkhoz, where she worked as a secretary, and also because of her concern with lists of "dead souls" and other "forged documents" In 1982 again compulsory hospitalized for similar reasons.

FEDOTOV, Viktor Viktorovich, born 1941.
USSR, Ussurisk, ul.Lermontova 37-1. On the psychiatric register since 1987. Biologist by profession, candidate of [biological] sciences, teacher at a VUZ [Factory university], has good recommendations from his earlier places of work. Disclosed deficiencies in the educational process, started to receive unconvincing and unfounded rebukes. When trying to have them annulled in court, he was given a psychiatric examination, with the following diagnosis: "Paranoid development of the personality".

TROITSIN, Vladimir Nikolayevich, born 1937.
USSR, Ryazanskaya oblast, Ryazanskii raion, p/o "Iskra", pos.Kutukovo. On the psychiatric register since 1984 in connection with the fact that he issued a complaint against regional doctors and the medical service in the oblast, as they refused medical help when his brother was ill.

KLADIYEV, Pavel Kuzmich, born 1925.
USSR 317900, Kirovogradskaya oblast, Aleksandriya, ul.Krasnokazachya 43-21. On June 28 1989, a week after he was fired from his place of work, where he worked for 18 years as a inspector, was summoned to the city committee of the Communiast Party for a conversation with a psychiatrist incognito. Knowing the psychiatrist by appearance, he refused to have the conversation. Believes they want to declare him mentally ill, because he planned to give compromising material of the party leadership to the procuracy.

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докт. мед. наук.

Консультант по социально-политическим вопросам:

Александр П. Подрабинек

VAINBERG, Perlya Bentsionovna, born 1935.
USSR, Tula, ul.Tulskaya 98a-85. Emigrated to Israel. On the psychiatric register since 1968 in connection with an industrial conflict, and also because of the anti-semitic attitude of the administration, according to her. Was declared not fit for work in 1973, but was declared fit for work later. Has two higher educations: pedagogy and law (?).

KAPTSEVICH, Klavdiya Pavlovna, born 1938.
USSR, Dnepropetrovskaya oblast, Nikopol, ul.Shevchenko 208-1. On the psychiatric register since 1985 at the initiative of the administration at her place of work for making critical remarks regarding the leadership. In 1986 left her job under pressure of the threat by the administration that she would be put in psychiatric hospital.

DEMURA, Nikolai Fyodorovich, born 1951.
USSR, Kiev, ul.Semirenko 12b-237. On the psychiatric register since 1985 for active exposure of deficiencies at work, from which he was fired: for "health reasons". Demura N.F. has some symptoms of neurastenia of the lungs, apparently due to his situation.

USOLTSEVA, Anna Pavlovna, born 1939.
USSR, 650065, Kemerovo, Oktyabrski prospekt 79-69. Lawyer by profession, on the psychiatric register since 1988 at the initiative of the administration, because of her refusal to leave her job voluntarily.

KUKHTO, Vyacheslav Vyacheslavovich, born 1955
USSR, Moscow, ul.Garibaldi 14-1-42. Was put on the psychiatric register in 1987, in connection with professional pressure by the administration, with the following diagnosis: "litigious-paranoid development of the personality". Kukhto V.V. is a lawyer by profession.

YAGODIN, Viktor Izmailovich, born 1967.
USSR 109428, Moscow, ul.Mikhailova 25-2, tel.:170-31-61. Was put on the register of a psycho-neurological dispansary at the age of 13 because he refused to wear a pioneer-tie and went to church.

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Александр П. Подрабинек

SMIRNOV, Viktor Ivanovich, born 1921.
USSR 384870, Gagry, ul.Tserteli 41/1-11. On the psychiatric register for political reasons. Disclosed a case of corruption amongst generals. Lieutenant-colonel of the Soviet Army, doctor, finished two faculties of the military medical academy. Was interned in Special Psychiatric Hospitals several times. Wrote an interesting monography about psychiatric abuse in the USSR and its socio-political basis.

KSHANOVSKY, Anatoly Maryanovich, born 1957.
USSR, Odesskaya oblast, Izmail, ul.28-iyunya, d.112.
On the psychiatric register since 1985 with the diagnosis "schizophrenia" for active participation in the process of perestroika. Many times compulsorily committed to a psychiatric hospital with fabricated amneses and symptoms.

ZIMAN, Lev Yanovich, born 1961.
USSR, Moscow, Tikhvinsky per. 7-32. Tel.: 251-13-40.
Was in 1989, as a taxi-driver, involved in small accident. Was not allowed back to work without undergoing a psychiatric examination, although there was no necessity for that. Siman L.Ya. was examined psychiatrically by the I.P.A. and found to be mentally healthy.

SHAKIN, Rostislav Ivanovich, born 1932.
USSR, Donetsk. Was put on the psychiatric register in 1981, in connection with going to the reception of the Central Committee of the Communist Party with personal questions.Was subsequently repeatedly committed to psychiatric hospitals and underwent compulsory treatment.

KARPESH, Lidiya Ivanovna, born 1936.
USSR, BSSR, Grodnenskaya oblast, Shogel, ul.Gorkogo 11-5. Was put on the register in 1984 in connection with a conflict-situation at her work. Was psychiatrically examined at work without permission of Karpesh L.I. and given a disability status of the 2nd category. Refused her pension as an invalid.

GRIBOYEDOV, Arkadii, Alerkseyevich, born 1941.
USSR 109125, Moscow, 1-ii Saratovski per 3-120. tel.: 1779613.
On the psychiatric register since 1979 in connection with his wish to emigrate from the USSR and also for having friendly relations with dissidents. Works as an artist and film-actor, his personality is somewhat hysterical.

IPA

НЕЗАВИСИМАЯ ПСИХИАТРИЧЕСКАЯ АССОЦИАЦИЯ

INDEPENDENT PSYCHIATRIC ASSOCIATION

ASSOCIATION PSYCHIATRIQUE INDEPENDANT

Президент:

Виктор Е. Лановой

129594, СССР, Москва
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Марьиной Рощи
д. 14-а, кв. 85

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Dr. V. Lanovoi
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Вице-президенты:

Леонид А. Китаев-Смык
канд. мед. наук.

Юрий С. Савенко
канд. мед. наук.

Секретарь:

Андрей А. Гостев
канд. психологич. наук.

Медицинский Директор:

Эдуард В. Семенов
психиатр

Научные консультанты:

Этелий Ф. Казанец
докт. мед. наук

Владимир А. Файвишевский
докт. мед. наук.

Консультант по социально-политическим вопросам:

Александр П. Подребенек

SERGIYENKO, Yekaterina Loginovna, born 1924.
USSR, Primorski krai, Arsenyev, ul.25-letiya Arsenyeva 27-19. On the psychiatric register since 1968 in connection with the fact that she likes and insists on rightiousness in society, "will not go against [my] conscience". Active campaigner. In 1989 she presented herself as a candidate for people's deputy [to the People's Congress] for her territorial district.

SARANTSEVA, Emiliya Grigoryevna, born 1940.
USSR, Moskovskaya oblast, Balashikha, ul.Fucheka 6-5-81. On the psychiatric register since 1985 at the initiative of relatives because of a quarrel over an apartment. Diagnosed as "schizophrenic" and given a disability status of the 2nd category.

TIKHOMIROV, Sergei Mikhailovich, born in 1935.
USSR, Moscow, ul.Kakhovka 14-2-127. tel.: 122-34-12. Put on the psychiatric register in 1987 at the initiative of the administration at work, in connection with the fact, that he indipendently investigated cases of dispropriation of state property at work in the "MOSKAPSTROIKOMPLEKT", where he worked as a brigadeer. Was diagnosed as being "schizophrenic" and given a disability status of the 2nd category.

FYDOROV, Fyodor Nikolayevich, born 1937.
USSR, Magadanskaya oblast, Pevek, ul.Pugacheva 50-25, tel: 2-26-24. Planned to go to a religious seminary in 1966. The administration at work prevented this. He announced (as he says, as a joke) that he planned to put himself on fire, and was compulsorily taken to a psychiatric hospital for that. Was diagnosed as a "schizophrenic".

KUKOBAKA, Mikhail Ignatievich, born in 1936.
Lives in Moscow without a registration-permit.
On the psychiatric register since 1970 in connection with his dissident activity. Underwent six years of compulsory treatment in Special Psychiatric Hospitals. Served 12 years in prisons and camps for political and human-rights activities. Was given the diagnosis "paranoid development of the personality", and sometimes "paranoid schizophrenia".

DECLARATION

Independent Psychiatric Association of the USSR

The Independent Psychiatric Association announces its foundation on the first day of the congress of the association which took place on March 9-11, 1989. The Independent Psychiatric Association declares its readiness to carefully work for the preservation of the health of mankind. The Association united all those, who consider it to be necessary to develop and improve the psychiatric science and practice, to defend the doctor against social and political pressure, to defend people, healthy or ill, against extreme socio-political and psychiatric arbitrariness, to work for his re-adaptation and rehabilitation.

The Association proposes the founding of an alternative psychiatric care working with various social and governmental organizations that don't participate in repressive actions.

The Independent Psychiatric Association turns to you with the proposal for cooperation with national psychiatric associations.

The Independent Psychiatric Association expresses its hope for a platform for scientific contacts, a mutual exchange of ideas and specialists, the organization of related projects and research activities in the field of topical social problems of psychiatry.

The Independent Psychiatric Association greets the psychiatrists of the whole world, all who are willing to defend the right of human beings to individuality, the right to remain oneself in whatever social-political surroundings, the right to a defence, the right to be healthy.

The Independent Psychiatric Association turns to all psychiatrists with the request to unite all their strength in the struggle for human rights and for the survival of mankind on earth.

Signed on behalf of the Independent Psychiatric Association,

Dr.V.Lanovoi, President
Dr.Yuri Savenko, Vice-President
Dr.Leonid Kitayev-Smyk, Vice-President
Dr.A.Gostev, Secretary

О Б Р А Щ Е Н И Е

Независимая Психиатрическая Ассоциация объявляет о своём учреждении, которое состоялось на I Съезде Ассоциации, проходившем 9-11 марта 1989 года.

Независимая Психиатрическая Ассоциация заявляет о своей готовности всячески способствовать сохранению здоровья человека. Ассоциация объединяет всех тех, кто считает необходимым развивать и совершенствовать психиатрическую науку и практику, защищать врача от социально - политического давления, защищать человека - здорового и больного в экстремальной ситуации социально-политического и психиатрического произвола, способствовать его реадаптации и реабилитации.

Ассоциация предполагает создание альтернативной психиатрической службы, взаимодействующей с различными общественными и государственными организациями, не участвующими в репрессивных акциях.

Независимая Психиатрическая Ассоциация обращается с предложением о сотрудничестве с Национальными Психиатрическими Ассоциациями.

Независимая Психиатрическая Ассоциация выражает надежду на плодотворность научных контактов, взаимный обмен идеями и специалистами, на организацию совместных проектов исследовательской деятельности по актуальным проблемам психиатрии.

Независимая Психиатрическая Ассоциация приветствует психиатров всего мира, всех тех, кто готов отстаивать право человека на индивидуальность, право оставаться самим собой в любой социально-политической среде, право на защиту, право быть здоровым.

Независимая Психиатрическая Ассоциация обращается с призывом ко всем психиатрам объединить усилия в борьбе за Человека, за его выживание на Земле.

Президент НПА Лановой Виктор Е.

Вице-президент НПА Савенко Юрий С.

Вице-президент НПА Китаев-Смык Леонид А.

Секретарь НПА Гостев Андрей А.

INDEPENDENT PSYCHIATRIC ASSOCIATION OF THE USSR

THE CONSTITUTION

1. GENERAL PROVISIONS

The Independent Psychiatric Association (IPA) of the USSR is a professional organisation of psychiatrists, psychoneurologists, psychotherapists and medical psychologists. "Independent" means not being subordinate to any state, medical or other administrative organisation, not being dependent on any political or scientific doctrine, striving for integration of the most promising scientific ideas and improvement of psychiatric service structures.

The Independent Psychiatric Association formulates its objectives and goals according to the concept of psychiatry as an integral discipline which studies psycho-pathological states of man, peculiarities of his psychic shifts in extreme situations, and collaborates productively with psychotherapy, medical psychology and medical sociology.

2. OBJECTIVES

2.1. To develop and improve psychiatric science on key directions of mental health problems.

2.2 To defend, rehabilitate and readapt people who become victims of psychiatric arbitrary actions, as well as all those who need psychiatric, psychotherapeutical and sociopsychological aid.

2.3 To defend a doctor from socio-political pressure and from attempts to influence his/her diagnostical and therapeutical decisions by considerations of a conformal and corporate type.

2.4 To create an alternative psychiatric service on the basis, in particular, of cooperative property and other principles mostly adequate for the concrete structure.

2.5 To increase the efficiency of treatment, rehabilitation and readaptation of the mentally ill, mentally retarded and the emotionally disturbed.

2.6 To improve the structure of psychiatric services as well as sanitary-higienic norms and conditions of people housed in psychiatric and psychoneurological hospitals.

2.7 To humanize Soviet psychiatric science and practice.

2.8 To facilitate cooperation of all those who are involved in studies of medical, psychological, social and legislative aspects of the problem of mental health and mental illness in the USSR and abroad.

2.9 To facilitate by all means an increase of professional knowledge of the members of the Association, to improve the system of special training of psychiatrists and medical psychologists, to implement the principle of "continuous studies", to provide for development of a high individual culture of all members of the Association.

2.10 To popularize psychiatric knowledge in psychosomatic and somatic medicine in other spheres of science and practice among the public.

2.11 To increase the psychological culture of the population. To introduce into practice the principles of psychohigiene and psychoprofilactics.

General Secretary
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Tel.: (020) 27 94 91

Information Bulletin
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Prof. R. S. Bluglass (UK)
Prof. Ch. Durand (CH)
Prof. Th. Kammerer (F)
Prof. S. Kety (USA)
Prof. P. Krauss (FRG)
Prof. H. M. v. Praag (NL)
Prof. V. M. Rakoff (CDN)
Prof. K. Rawnsley (UK)
Prof. H. Rooymans (NL)
Prof. P. Sivadon (F)
Prof. H. Solms (CH)
Prof. J. Sutter (F)
and:
Prof. J. Hersch (CH)
Tom Stoppard (UK)

Honorary members
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Dr. A. I. Koryagin

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A. Podrabinek (USSR)
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Dr. J. Jeffries (CDN)
Prof. P. B. Reddaway (USA)

Legal advisor
Prof. Ch. A. Junod (CH)

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INTERNATIONAL ASSOCIATION ON THE POLITICAL USE OF PSYCHIATRY

ASSOCIATION INTERNATIONALE CONTRE L'UTILISATION DE LA PSYCHIATRIE A DES FINS POLITIQUES

INTERNATIONALE VEREINIGUNG GEGEN DIE POLITISCHE VERWENDUNG DER PSYCHIATRIE

LETTER BY SOVIET PSYCHIATRIST DENOUNCING VARTANYAN

Introduction

Professor Marat Vartanyan is a Soviet psychiatrist currently manouvring to become top official in his profession. Vartanyan has long been known in the West for his sweeping denials that psychiatrists lock up Soviet dissidents in mental hospitals and torture them there with powerful drugs. His manipulative efforts to counter widespread protests on the issue have also gained him notoriety. Less well known is his equally unsavory reputation inside the USSR.

Vartanyan has been Director of the All-Union Research Center for Mental Health since late 1987. The All-Union Research Center includes, in particular, the Institute of Psychiatry of the Academy of Medical Sciences and the Kashchenko hospital in Moscow. Vartanyan was appointed to that post by his good friend, the Minister of Health of the USSR, Dr.Yevgeni Chazov, in spite of a rather nasty affair in 1985-1987, when the disciplinary commission of the Communist Party carried out an investigation against him on charges of corruption. The accusations consisted of financial irregularities, plagiarism, involvement in abuse of psychiatry, administrative manipulation and involvement in corrupt actions by his associates. Vartanyan was severely interrogated by the party disciplinary committee, under the chairmanship of Politburo-member Solomentsev. Vartanyan was finally let off with a party rebuke, but his position was much weakened. The demotion of Moscow Party-Chief Yeltsin in November 1987, however, changed the political climate in the USSR and enabled Minister of Health Chazov to push through his friend's promotion.

Vartanyan is the main competitor of Serbski Institute Director Morozov for leadership over Soviet psychiatry. However, in October 1988 Vartanyan did not succeed to have his client Alexander S.Tiganov elected to Presidency of the Soviet All-Union Society, in spite of intense politicking by WPA President Costas Stefanis in favor of Vartanyan's candidate.

Professor Vartanyan became Associate Secretary of the World Psychiatric Association in 1971. He quickly became an outspoken apologist for the political abuse of psychiatry in his country, stating that no sane people were being held in Soviet psychiatric hospitals: "The nature of our system is such that this could not possibly happen". In subsequent years he continued to defend Soviet psychiatry, without refraining from blatant lies.

IAPUP is a confederation of national groups which opposes the political use of psychiatry wherever it occurs, and seeks the release of all direct and indirect victims of this practice.
IAPUP is totally independent.

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ASSOCIATION INTERNATIONALE CONTRE L'UTILISATION DE LA PSYCHIATRIE A DES FINS POLITIQUES

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In 1978 Vartanyan was one of the signatories of a letter, in which Soviet psychiatrists warned that if the Review Committee on Political Abuse of Psychiatry of the WPA were to be established, the Soviet All-Union Society would refuse to recognize it. The Soviets subsequently refused to cooperate with the Review Committee.
From 1977 to 1983 Vartanyan was a member of the Committee on Ethics of the World Psychiatric Association, under chairmanship of the current WPA President Costas Stefanis.

Hitherto, Soviet psychiatrists with the best information about him have been too frightened of his power to speak up in public. Nopw the silence has been broken. The Soviet Union's most outstanding psychiatric geneticist, Dr Viktor Gindilis, has protested in a bold "open letter" to the USSR Medical Science Academy that Vartanyan does not deserve the title of Academician, which the Academy is due shortly to bestow on him.
The letter, a copy of which has just reached the West, argues that both scientific and moral considerations should bar Vartanyan from the coveted title. On the basis of first-hand observation Gindilis accuses him of systematic plagiarism and a ruthless ambition which has led to the deaths of several colleagues. Many of the charges were known to Western specialists from private conversations with psychiatrists in the Soviet Union and colleagues of theirs who have emigrated. Others have been checked out since the letter was received. By all accounts the charges are well founded.
Hereby we publish the text of Dr Gindilis' letter in full.

"OPEN LETTER TO THE BIOLOGICAL MEDICINE DEPARTMENT OF THE USSR MEDICAL SCIENCE ACADEMY"

It is clearly unjustified to "reserve" for M.E. Vartanyan the Medical Science Academy's elective position for a "geneticist specialising in mental illness." Since his activity as an academic manipulator has long needed investigation by the State Prosecutor's office, I feel compelled to bring a number of important matters to the attention of yourselves, and of the leaders of the Academy, the Ministry of Health, and the Science Department of the Party Central Committee.

1. I am the real author of almost all the publications and research initiatives attributed to M.E. Vartanyan in the field of medical genetics, particularly as regards the genetics of mental illness. I am also a scientist who for the last twenty years has been kept in a position of humiliating, serf-like dependency on this scientific functionary, whose criminal activity has with each year become more obvious and more ominous. As such, I assert with all responsibility and a clear understanding of the possible consequences for myself, that <u>there is no immoral or unscrupulous act that Vartanyan would not commit for the sake of his careerist goals</u> [here and below, italics in the original].

The real moral level of this would-be Academician has been revealed specially vividly by tragic recent events involving the simultaneous deaths of two scientists at our Center, which resulted from the disorder in Vartanyan's own laboratory, and even more by subsequent cover-up attempts which included the forgery of documents and the spreading of slander about those who perished.

2. Although Vartanyan presents himself, when it suits him, as a medical geneticist, he has not in fact received or examined a single patient for the last thirty years, and has not written a single case history or a single report on any individual. Vartanyan is simply illiterate even in simple issues of medical genetics, and when it comes to complex aspects of the contemporary genetics of mental illness and molecular neurogenetics, he is completely incompetent. Throughout his career as an official he has not himself devised a single scientific experiment, and has not formulated a single, even slightly original scientific idea.....

Everything he attributes to himself in official papers submitted to top bodies, e.g. in connection with the forthcoming Academy elections, is the fruit of the creative work of particular scientists. Most of these people have been cruelly done in by him as he has climbed the administrative ladder. This is thanks to the constant protection afforded him by a certain

group of people in the Science Department of the Central Committee, the Ministry of Health, and the Medical Science Academy. Such was the pattern with his doctoral dissertation, which was mostly written for him by V. Faivishevsky, who had also done the preliminary work for it, and who was later kicked out of the Academy's Institute of Psychiatry (where Vartanyan was an administrator). This was the pattern with his higher doctoral dissertation, which several scientists in the pathophysiology lab took part in writing. The principal figures among them were later forced to resign, or even to emigrate. The latter was the case with D.V. Lozovsky, who, before his departure, said straight out that "persecution of me by Vartanyan is the main reason for my taking such a painful decision."

Finally, the award of the title Corresponding Member of the Medical Science Academy to Vartanyan, as a "geneticist of mental illness", resulted from his presenting as his own personal achievement the important scientific fruits of my own work and my joint work with students and colleagues, and also of the collective findings of a group of clinical geneticists headed by I.V. Shakhmatova-Pavlova. This group and I worked fruitfully together for many years, building the prestige of our country's genetics, while Vartanyan exploited our results, presenting them during his many foreign trips as his own.

Eventually the fate of some of my colleagues struck me too. In 1985 Vartanyan destroyed the unique group of scientists I had built up[1], which had already registered considerable successes and was fast developing its creative potential (a potential which the Academy of Sciences is only now trying to realize in its well known project "Through the human gene"). This act of destruction cost the life of one of my leading students, Yu.A. Shapiro, deputy head of the laboratory, who died at the age of 38. After this, Vartanyan forced a young doctoral student in the lab to appropriate Shapiro's and my joint findings, and Vartanyan has now put these forward for the Academy election as an outstanding achievement of his scientific leadership in the field of molecular neurogenetics.

3. Analogous cases in the "scientific career of both Vartanyan himself and his wife D.D. Orlovskaya, who "directs" the laboratory of pathomorphology in the same institute, are not few in number. Probably it is a unique situation for the Academy where two spouses who head specialized labs in a single scientific institution should neither of them have the professional right to do so, since they have never earned it by presenting even formal documents to prove they possess the relevant specializations. For many years Orlovsky has

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[1]In the genetics laboratory of the All-Union Research Center for Mental Health of the Medical Science Academy

"directed" the clinical pathomorphology lab without having the legal right to do pathomorphology research, and without even knowing how a microscope is built, or how to use it, or what the special techniques are for pathomorphology and the cytopathology of the nervous system. In the early 1970s the head of the lab, the well known pathomorphologist V. Podymov, was forced out by Vartanyan after a lengthy campaign of harassment. The ideas of this highly promising young scientist then began to be developed under the joint "direction" of Vartanyan himself and Orlovskaya, and Orlovskaya became the lab head in place of Podymov.

Not surprisingly, Podymov, who was under forty and at the peak of his creative powers, soon died. It was also not surprising that a young scientist in Orlovskaya's lab, V. Salnikov, committed suicide in tragic circumstances, and three months later his scientific supervisor Yu. Savulev (also a youngish man of 35) suddenly died. No one was surprised either when the most talented researchers, people like Yu. Lashchilov, began to quit the lab, and those who did not go quietly were forced out by cruel, debilitating persecution from Vartanyan and Orlovskaya. This is what happened with the destruction of the promising research group of Zh.V. Solovyova, who did not break, but whose life they poisoned with false rumors of alleged psychiatric problems and administrative failings.

4. The protection enjoyed by Vartanyan in high places has for many years enabled him to conceal from the scientific community and the public at large any scandal involving himself or his wife. This protection long ago taught the employees of the Insitute of Psychiatry, and then of the Research Center for Mental Health, to give their formal "agreement" to any of his actions, even though everything described in this letter has been well known to many of them. The view that Vartanyan is an adventurer, an academic manipulator, a fixer, an unprofessional administrator, etc., is shared by many people, including even former leaders of our Center like Academician A.V. Snezhnevsky, Professors R.A. Nadzharov and Polyakov, and others, and this view has often been stated in public. However, many institute employees have been trained over the years to lack courage and honesty, and this fully explains why I am alone in being ready to expose in writing a situation in our Research Center which recalls the rule of Adylov and Rashidov.[2] The fact that those who express discontent with Vartanyan's pernicious regime have not yet been put in dungeons is of limited comfort. In every other respect, life under the administrative "leadership" of

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[2] Corrupt leaders in Uzbekistan. Rashidov died in 1983, but Adylov was recently arrested and charged with being a feudal despot who tyrannized his area and locked up opponents in his personal prison.

Vartanyan is humiliating and shaming, not to speak of course about the small group of those who assist and fawn on him.

5. The role of Vartanyan's protectors showed especially vividly in the story of how he was "elected" as director of our Center (in December 1987) by a bureau of the Medical Science Academy. The outcome was the result of behind-the-scenes pressure and an autocratic decision. First, the decision went against the wishes of the majority of the Center's staff, which was clearly expressed in a resolution of the staff union, and also against the wishes of a number of high bodies, including Party ones. And second, it ignored the fact that not long previously a special commission of the Central Committee's Party Disciplinary Committee had, in the face of powerful pressure from the forces protecting Vartanyan, nonetheless officially confirmed that he had grossly abused his official position and violated the norms of scientific ethics. To all appearances, however, the administrative reprimand imposed on him by the Party was viewed by him and his associates as merely a temporary hiccup in the long-established and well-oiled machine which has covered up all his work-related crimes.

6. I can not pass over one further matter of great importance. It is well known that in recent years Soviet psychiatry and its leaders have been subjected to criticism. As a specialist in the clinical genetics of mental illness[3], I have never agreed with many aspects of this criticism, just as I have not supported the widespread attempts of recent times to idealize certain scientific concepts of psychiatric diagnosis and some of its specific features. However, leaving such nuances aside, I think it would be proper for any half-decent person who has fought long and hard to become the leader of Soviet psychiatry to shoulder the burden of responsibility both for the concepts and for the diagnoses (on dissidents), along with the others responsible. However, unlike these other leaders, it is Vartanyan who, in today's conditions of "perestroika and new political thinking", is using all his hidden connections, including his foreign links, to discredit the recent leaders of psychiatry and to get them replaced by himself. He is doing this despite the fact that in the past he was the most active person on such matters (though he had no professional basis on which to be so).

7. All the above is only a small part of what Vartanyan ought, on the basis of documents, to be charged with. Nothing new would probably be added to the picture of him as an academic

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[3] My twenty years of professional work has been and is being given attention by such leaders of Soviet psychiatry as A.V. Snezhnevsky, G.V. Morozov, R. A. Nadzharov, N.M. Zharikov, and others.

manipulator by listing the occasions on which he has senselessly wasted foreign currency, illegally spent state funds for non-designated purposes, cooked the books, and committed scientific bluff. But the indifference with which the leaders of the Academy and the Health Ministry view all this is interpreted both by him and, of course, by the staff of the Center as encouragement for his philosophy that "anything goes". The tragic sort of consequences that this whole corrupt, demoralizing atmosphere leads to in our scientific Center has been described above. And although only a few days have gone by since the latest tragedy, no one on the staff doubts that once again Vartanyan will quickly manage to hush everything up. The fact that, inevitably, many staff members have been drawn into the process of falsifying documents only suits this functionary, since it binds many people in a system of mutual dependency. The ethical corruption of subordinates by various means, and the ability to prove his usefulness to top nomenklatura officials- these are probably the only two things that Vartanyan does professionally.

As for the future of genuine science and the fate of those who work with honesty and dedication but can not bear the way an undoubted criminal cripples the country's science - all this clearly does not bother the leaders of the Academy and the Health Ministry, since the reservation of a seat as an Academician, specially for Vartanyan, has now been sanctioned.

One can only express futile surprise that at a time when perestroika has been proclaimed, the very title of Academician is being debased. The evidence for this is that such obvious careerists as M.E. Vartanyan, for whom scientific looting and administrative banditry are the ethical norm, have enjoyed such longstanding and sure protection within the Academy itself, the Health Ministry, the State Planning Committee, and the Science Department of the Central Committee.

25 November 1988

V.M. Gindilis, Doctor of Biological Science, Head of the Genetics Laboratory, Brain Research Institute, All-Union Research Center for Mental Health, USSR Academy of Sciences.

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INTERNATIONAL ASSOCIATION ON THE POLITICAL USE OF PSYCHIATRY

ASSOCIATION INTERNATIONALE CONTRE L'UTILISATION DE LA PSYCHIATRIE A DES FINS POLITIQUES

INTERNATIONALE VEREINIGUNG GEGEN DIE POLITISCHE VERWENDUNG DER PSYCHIATRIE

DOCUMENTS

ON THE POLITICAL ABUSE OF PSYCHIATRY IN THE USSR

19

(April 1989)

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SOVIET ALL-UNION SOCIETY PROVISIONALLY BACK IN WPA

It appeared to be a well-organized overture. Without even most members of the Executive Committee of the World Psychiatric Association (WPA) knowing, professor Nikolai Zharikov, chairman of the Soviet All-Union Society of Psychiatrists and Narcologists (AUSPN), and Dr.Pyotr Morozov of the All-Union Research Center for Mental Health were invited to attend the Regional Symposium of the WPA, held in the Spanish city of Granada on March 27-April 1, 1989. Then, without prior notice, professor Zharikov appeared at one of the sessions and gave an unannounced speech, mainly consisting of the verbatim text of the new 'Regulation concerning the circumstances and procedures for administering psychiatric treatment', passed by the Presidium of the Supreme Soviet of the USSR on 5 January 1988 (See Documents, no.6). And finally, equally secretively, the Soviet application for re-entry into the WPA was tabled at an Executive Committee meeting on March 29. Provisional membership of the WPA for the AUSPN was the result.

Although we will certainly return to both the issue of the Soviet provisional re-entry into the WPA and the Granada meeting in future issues of the Documents, we would like to give you an initial account of what actually happened during the Regional Symposium in Granada. Further details, as said, will follow in the next issues of the Documents. We will first give you a day-to-day account of what happened behind closed doors, and then discuss various aspects of the issue.

March 28, 1989
During an Executive Committee meeting the application by the Soviet AUSPN for re-entry into the WPA is raised. When asked what happened to the application for membership by the Independent Psychiatric Association of the USSR (IPA), the General Secretary says it will be discussed during a later Executive Committee meeting.

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March 29, 1989
Zharikov appears unannounced at a session and gives a speech on the new regulation in the USSR. He evades questions on political abuse of psychiatry.
During a meeting, the Executive Committee discusses the application for re-entry into the WPA by the AUSPN. Schulsinger proposes to vote on their applications. Associate Secretaries Dr.Jorge Alberto Costa e Silva and Dr.Melvin Sabshin object. Dr.Costa e Silva objects because the application by the Soviets is not signed by anyone and therefore not legal, Dr.Melvin Sabshin because he feels the Executive Committee should wait for the report of the U.S. psychiatric delegation to the USSR (see Documents no.18) to come out and because the Soviet application is not a normal one, as a resolution was passed in 1983 regarding a possible Soviet return. Dr.Schulsinger presses for a voting; four vote in favor (Dr.Fini Schulsinger, Dr.Costas Stefanis, Dr.Jochen Neumann and Dr.Neils Reisby), two abstain from voting (Dr.Jorge Alberto Costa e Silva and Dr.Melvin Sabshin). The President of the WPA, Dr.Stefanis, is asked whether the document, on basis of which the Executive Committee just voted to give the AUSPN provisional membership, is an official document. Dr.Stefanis answers: no, this is not an official document, we will get a signature tomorrow an then everything is allright.

A next issue on the agenda is the application for membership of the IPA. This application is turned down, because the new association applied too late (according to the Statutes and Bye-Laws of the WPA an application should not reach the General Secretary later than twelve months prior to the next General Assembly of the WPA (therefore, before October 11, 1988). It appears that Dr.Schulsinger wrote the AIP before the Executive Committee Meetings in Granada, informing them that their application was turned down, without consulting the Executive Committee.

March 30, 1989
Professor Zharikov of the AUSPN is asked to sign the papers regarding their application for membership of the WPA, that is, one day after the Executive Committee voted on its provisional membership. After that, Zharikov gives an interview to Spanish radio, in which he denies there is any psychiatric abuse in the USSR and says that the Soviets sofar didn't come to Regional Symposia of the WPA because they did not want to (so: not because they were forced to withdraw from the WPA in 1983). Apparently, the same day Zharikov and Pyotr Morozov leave Granada.

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The same day another meeting of the Executive Committee takes place. The members of the Executive Committee are shown the paper signed by Zharikov anmd asked whether they accept this as an official document. Dr.Costa e Silva says no, as the voting took place a day earlier on basis of a non-signed paper.

April 1, 1989
An 'open' joint session of the Executive Committee, the Committee of the WPA and representatives from psychiatric associations takes place. The re-admission of the AUSPN is only mentioned in passing.

At this stage, it is important to explain in what manner the AUSPN applied for re-admission into the WPA. On October 9, 1988, the All-Union Society of Psychiatrists and Neuropathologists (please note the name) sent a telegram to the General Secretary of the WPA, informing the WPA that the AUSPN would consider an application for membership of the WPA at its next congress, to be held at the end of October 1988 in Moscow. On October 28, 1988, the All-Union Society of Psychiatrists and Narcologists (note the change of name) decided to apply for membership of the WPA. First of all, October 28, 1988, is less than twelve months prior to the next General Assembly of the WPA and therefore too late. Secondly, not only the name of the AUSPN changed, but so did the whole Society: the Neuropathologists withdrew from the AUSPN and set up their own association, while the Narcologists joined the Psychiatrists. Therefore the telegram of 9 October 1988, even if it could be considered to be an application, did not concern this new association, but an old one that ceased to exist.

According to the WPA regulations, an application for membership of the WPA should
a. be signed by the President and the Secretary of that association;
b. be accompanied by a statement that more than two-thirds of the members are psychiatrists and by the consitution of that association;
c. should be based on a resolution adopted by the members of such a association;

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Now the Soviet 'application' was neither signed by the President nor by the Secretary, the documents required by the WPA regulations were sent only in March 1989 and were not shown to other members of the Executive Committee and the resolution to apply for membership of the WPA was passed by the new AUSPN only on October 28, 1988, two weeks later than the closing date of October 11, 1988.
In fact, the Soviet AUSPN only signed their application on March 30, 1989, and thereby made the application a legal document. Therefore one can not only wonder whether the voting on March 29 was legal, but also whether it is correct that the application of the Independent Psychiatric Association (dated and signed March 9, 1989) was turned down and the application of the AUSPN (signed three weeks later, on March 30, 1989) was accepted.

The course of events in Granada, the secrecy surrounding the decision-making by the Executive Committee of the WPA and the clear existence of a small Executive within the Executive Committee (mainly consisting of Dr.Schulsinger and Dr.Stefanis) leave a very bitter taste and a clear impression that the Soviet re-entry was pushed through at all costs. Why this small Executive within the Executive Committee was in such a great hurry, one can only guess. Possible they feared the outcome of the report by the U.S. psychiatric delegation to the Soviet Union, due to be published later in April. They might have feared that the conclusions by this delegation would seriously obstruct a Soviet return. Another reason might be that the small Executive felt that by giving the AUSPN provisional membership, the member-associations of the WPA would get accustomed to the presence of the AUSPN within WPA ranks and that the final voting by the General Assembly in October in Athens, whether to accept the AUSPN or not, would be more of a formality.

IAPUP is not only very concerned because of the fact that only few individual members of the WPA Executive Committee (and certainly not the small Executive within the Executive Committee) have shown any interest in the reasons why IAPUP opposes a return of the AUSPN under the present circumstances, but also because of the clearly undemocratic way in which the provisional membership of the AUSPN was pushed through.

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IAPUP strongly favors a well-organized and democratic World Psychiatric Association, strong on ethical issues. It favors a truly world association, in which member-associations have control over decisions taken by the Executive Committee. The provisional return of the AUSPN, and the way in which this return was carefully and secretively prepared by the small Executive within the Executive Committee, clearly indicate that the current WPA cannot be considered to be such an association.

The decision to grant provisional membership of the WPA to the AUSPN, and the denial to grant a similar status to the IPA, is a slap in the face of reformist forces within Soviet psychiatry and are feared to hamper very much any reforms in this scientific field. We feel that this decision was unnecessary, untimely and short-sighted. We therefore call on all individual psychiatrists and all psychiatric associations to join our campaign for a Soviet psychiatry free of abuses, and for a democratic and truly world psychiatric association, that will be strong on ethical issues and that will combat abuses wherever they occur.

Robert van Voren,
General Secretary.

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From the Secretariat

In our Documents no. 19 we gave you a first report on the Executive Committee meetings in Granada and the Regional Symposium in that Spanish city. In this issue we would like to give you a more detailed report. Regarding the legality of the decision to grant provisional membership of the WPA to the All-Union Society of Psychiatrists and Narcologists (AUSPN) of the USSR, we would like to quote from a memorandum written by our legal advisor, Professor Charles Junod:

> "...It seems quite obvious to me that the telegram from the Soviet All-Union Society... does not constitute a formal application for membership, but rather some sort of pre-announcement, as it indicates that "members of All-Union Society of Neuropathologists and Psychiatrists put question of enrolment with WPA" and, even more important, that "final decision of Board be sent nearest future".
> "...It does not seem necessary to me to spend much time on the interpretation of the above mentioned telegram, considering the provision of clause 5 of the Bye-Laws whereby "requests for membership... must be accompanied by an excerpt of the Resolution passed by the Society requesting membership to the World Psychiatric Association". In the light of that provision, it is clear to me that the said telegram, presumably emanating from the Committee of the All-Union Society of Psychiatrists and Neuropathologists, cannot be regarded as an "application for admission" within the meaning of the second sentence of clause 5 of the Bye-Laws of the WPA. Therefore, if the ordinary General Assembly of WPA which would have decided on the request for membership of the All-Union Society is to be held within less than twelve months after the date upon which a formal application for admission will be addressed to the Secretary General of the WPA, it could not be considered by the General Assembly..."

The above leaves no doubt: the All-Union Society of Psychiatrists and Neuropathologists did not apply twelve months prior to the next General Assembly, as required by the WPA Statutes and Bye-Laws. On top of that, the All-Union Society of Psychiatrists and Neuropathologists ceased to exist on October 28, 1988.

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The new association, the All-Union Society of Psychiatrists and Narcologists, sent their papers only in March 1989, and they were not signed. They were only signed on March 30, the day after the voting by the Executive Committee of the WPA.
This makes first of all the voting on March 29 unconstitutional and therefore void, secondly according to the Statutes and Bye-Laws the AUSPN should never have been given provisional membership, as they did not meet the requirements set in the regulations of the WPA.
Thirdly, the application of the AUSPN cannot be considered to be a normal application, because of the resolution adopted by the General Assembly in 1983, which reads:

> "The World Psychiatric Association would welcome the return of the All-Union Society of Neuropathologists and Psychiatrists of the USSR to membership of the Association, but would expect sincere co-operation and concrete evidence beforehand of amelioration of the political abuse of psychiatry in the Soviet Union".

It should have been up to the General Assembly to decide whether there is such "concrete evidence of amelioration of the political abuse of psychiatry in the Soviet Union", and not up to an Executive Committee, meeting half a year before the next General Assembly, and itself deeply devided over this issue. Dr.Melvin Sabshin, an Associate Secretary of the WPA, abstained from voting precisely because he felt this should have been left to the General Assembly to decide. Secondly, he felt that the Executive Committee should have awaited the outcome of the report by the U.S. psychiatric delegation to the USSR (see Documents no.18).
Considering the events in Granada, one cannot help thinking that exactly the forthcoming publication of this report by the U.S. psychiatric delegation caused the Secretary General of the WPA, Professor Fini Schulsinger, to be in such a hurry. Foreseeing that the outcome would indicate that there is no "concrete evidence of amelioration of the political abuse of psychiatry in the Soviet Union", he had to be quick. If the Soviet AUSPN were back provisionally, the effect of the publication of the U.S. report would be less sharp, so he may well have thought, and the member-associations would have time to get used to the idea of having the Soviet AUSPN back in the WPA, whereby the voting on the membership of the AUSPN would turn more into a formality.

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The hurried and unconstitutional return of the AUSPN, however temporary it might be, clearly shows that the current WPA leadership is neither interested in ethical issues nor interested in helping the Soviets to reform their psychiatric service. Events in the past have given the same indication. For instance, the Review Committee of the WPA, instituted in the Statutes and Bye-Laws by the General Assembly of the WPA in Vienna in 1983, was made totally ineffective by the Operational Instrument written by the Executive Committee. As a result, it hardly met and has not produced any work of substance. The difference between the Review Committee on Political Abuse of Psychiatry which existed from 1977 and 1983 and was well led by Professor Jean-Yves Gosselin, and the current Review Committee is both striking and shocking. Of course, one can question why none of the members of the Review Committee ever raised the issue of changing the Operational Instrument. Whatever the answer to that question might be, it is clear that there was never any initiative by the Executive Committee to improve the status of the Review Committee.

Further, a symposium on "Soviet psychiatric abuse in the Gorbachev Era", proposed by our association, was banned from the Regional Symposium of the WPA in Washington D.C. in October 1988. A symposium on "Ethical conflicts for the publicly employed psychiatrists", proposed by Dr.John Grigor from Australia, was not included as such in the programme of the Regional Symposium of the WPA in Granada but squeezed into a session on "planning". At the same time, the President of the AUSPN, Professor Zharikov appeared unannounced on the panel of a session on "Ethic and Legal Aspects of Mental Health Care in the Community" and read the new regulation on psychiatric help in the USSR which, while it is being severely criticized even in the Soviet press as being wholly unsufficient, was presented by him as proof that the rights of psychiatric patients are guaranteed in the USSR.

The way in which the provisional return of the AUSPN, which is still led by criminal psychiatrists, was brought about, and the fact that the Independent Psychiatric Association of the USSR was refused a similar status, show that the current WPA-leadership does not support the 'perestroika'-forces in the USSR, but rather supports those psychiatrists who have turned their science into a tool of repression and who have severely damaged the reputation of psychiatry in general.

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The Soviet issue is just one example of how undemocratic the WPA has become. By means of pure manipulation, bending the rules as much as possible and sometimes directly violating them, some officers of the WPA Executive Committee try to reach their goals.
For Professor Schulsinger, the newly proposed voting structure is not so much an attempt to democratize the WPA, as more a means to facilitate the return of the AUSPN, as he openly told me in October 1988 (see Documents no.11).
Also the introduction of the new Statutes and Bye-Laws, of which the voting structure is only a part, is being prepared in the same manner. By introducing an extraordinary General Assembly, to take place on October 11, many regulations regarding an ordinary General Assembly are evaded. At the moment, it seems the agenda of the extraordinary General Assembly will be as follows: 1. application of new members; 2. position of non-paying members; 3. new Statutes and Bye-Laws. However, as this concerns an extraordinary General Assembly, it is no problem to change the sequence of the agenda, which otherwise (if it were an ordinary General Assembly) would need to have a set sequence. This means, that the new Statutes and Bye-Laws could be put to the vote first, which would change the voting-system if it is adopted, and then one could proceed with the applications of new member-associations.
It seems some members of the Executive Committee (the "Executive" within the Executive Committee) plan to propose the new Statutes and Bye-Laws not as new Statutes and Bye-Laws, but as amendments to the Statutes and Bye-Laws. They hope that thereby the changes will have effect immediately, and that voting regarding applications of new societies can so take place on basis of the new voting structure. It is clear that this new voting structure would sharply increase the chances for the AUSPN to get full membership. Schulsinger's statement to me, as recorded above, makes clear that such is the plan.
The "Executive" within the Executive Committee clearly feels that the member-associations will not object to their plans and to the proposed "amendments" to the Statutes and Bye-Laws. Being sure of themselves, they apparently have already contacted their legal advisors for approval of the new Statutes and Bye-Laws, or, as they want to put it, the "amendments" to the Statutes and Bye-Laws.

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Finally, in order to accommodate the AUSPN and to facilitate their return, it is their plan to ask new associations only half the dues for 1989. The official reason for this decision would be, that the new associations only start functioning fully in the WPA after the Athens congress. However, as it is hard for Soviet organizations to get Western currency, such a decision in reality would facilitate the AUSPN to pay their dues and have all their votes. In 1977, for instance, the Soviets did not have all their thirty votes as they had not paid their full dues. Now, if they would be accepted as full members during the extraordinary General Assembly, they would have their thirty votes during the ordinary General Assembly, while paying close to nothing. Their thirty votes could help certain psychiatrists, who helped them to rejoin the WPA, to get (re-)elected to the Executive Committee of the WPA.

Finally, if we come to the application for membership by the Independent Psychiatric Association of the USSR, one should note that, although their application was late according to the current Statutes and Bye-Laws, they would have been in time under the amended Statutes and Bye-Laws - which state that applications should reach the WPA six months prior to the next General Assembly. Secondly, as said, their letter was signed on March 9, 1989, while the AUSPN signed their letter on March 30 and were admitted provisionally. The application of the Independents was made in accordance with the Statutes and Bye-Laws, and it hard not to feel that the decision of the Executive Committee (or, rather, the "Executive" within the Executive Committee) was arbitrary. If the AUSPN is admitted to provisional membership, the same should apply to the Independents. Now the Executive have clearly taken sides: in favor of anti-'perestroika' and criminal psychiatrists. This is one more example that the current leadership is not in favor of ethical issues and is supportive of the Old Guard of Soviet psychiatry, which has caused so much disgrace to Soviet psychiatry in particular and to world psychiatry in general. It is, of course, not so surprising: in spite of the repeated condemnation of Soviet abusing psychiatrists by the WPA (1977 and 1983), Profs. Schulsinger and Stefanis have maintained excellent contacts with

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them. For instance, as early as 1984 Professor Stefanis invited an official Soviet psychiatrist to participate in a WPA symposium in Athens, and was only forced to withdraw the invitation under pressure of strong protests from Greek colleagues. Over the years he maintained intensive contacts with Professor Vartanyan, a psychiatrist accused of being a criminal even by his own colleagues (see Documents no.16). As early as 1987, he was lobbying for a Soviet return into the WPA, a campaign in which also Professor Schulsinger participated and which was documented by IAPUP in our Information Bulletin no.18. By pulling the Soviet AUSPN back into the WPA, they have 'legalized' the contacts they have maintained over the past six years.

These latest developments are of major concern to IAPUP, not only because we feel the AUSPN should not be allowed to rejoin the WPA while the same criminal psychiatrists are in power and the political abuse of psychiatry is continuing, if at a reduced level, but also because an undemocratic WPA ceases to be an arena where abuse of psychiatry for political purposes and other unethical practices can be fought. Such a development is a bad service to world psychiatry.

Robert van Voren,
General Secretary.

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ON THE POLITICAL ABUSE OF PSYCHIATRY

IN THE USSR

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(May 1989)

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ONCE MORE: LEGAL ASPECTS REGARDING THE GRANADA MEETING OF THE WPA-EXECUTIVE

In the last two issues of our Documents (nos. 19 and 20) we reported in detail the Executive Committee meetings that took place in Granada, Spain, between March 28 and April 2, 1989. These meetings took place while a Regional Symposium of the WPA was held in that city. During the Executive Committee meetings, the Soviet All-Union Society of Psychiatrists and Narcologists was given provisional membership of the WPA, while an application from the Independent Psychiatric Association of the USSR was turned down. In the earlier two reports we questioned the legality of the decision of the Executive Committee of the WPA; in this third report we would like to add comments from our legal advisor, Professor Charles-André Junod from Switserland.

1. The Soviet application

In Documents 19, we reported that on October 11, 1988, the All-Union Society of Psychiatrists and Neuropathologists sent a telegram to the General Secretary of the WPA, informing the WPA that the AUSPN would consider an application for membership of the WPA at its next congress, to be held at the end of October 1988 in Moscow. According to the WPA regulations, an application for membership of the WPA should
a. be signed by the President and the Secretary of that association; b. be accompanied by a statement that more than two-thirds of the members are psychiatrists and by the consitution of that association; c. should be based on a resolution adopted by the members of such a association.
Now the Soviet 'application' was neither signed by the President nor by the Secretary, the documents required by the WPA regulations were sent only in March 1989 and the resolution to apply for membership of the WPA was passed by the AUSPN only on October 28, 1988, two weeks later than the closing date of October 11, 1988.
In fact, the Soviet AUSPN only signed their application on March 30, 1989 (see point 4 of this report).

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We asked Professor Junod what an "application for membership" actually means - is it enough to "show interest" in applying for membership, or is it necessary to explicitly state that one wants to join the association? Professor Junod answered:

"Regarding the concept of "Application for admission to Membership", under Item 6 of the Statutes of WPA, there is no doubt that such an application must consist in a formal declaration to apply for Membership. This is made quite clear by the provision of clause (5) of the By-Laws whereby "the application for admission must be accompanied by a copy of the Resolution passed by the Society in request of WPA Membership". Therefore, a mere declaration of an intention to possibly join WPA does not constitute an application within the meaning of Item 6 of the Statutes and of clause (5) of the By-Laws.

"Accordingly, the telegram addressed by the Soviet All-Union Society to WPA's Executive Committee on October 11th, 1988 does not constitute a formal application for Membership, but rather some sort of pre-announcement, as it indicates that "Scientific Society of neuro-pathologists and psychiatrists put question for enrollment with WPA" and, even more clearly, specifies that "final decision of board be sent nearest future".

"Therefore, the twelve month notice period provided for by the second paragraph of clause (5) of the By-Laws of WPA cannot be computed from the date of the above mentioned telegram, but only from the date when a formal application, complying with requirements of the said clause (5), has been received by the Secretary General of WPA. As long as the Articles and By-Laws of WPA have not been modified in that respect, a different solution would require the unanimous consent of all members of WPA."

2. The change of name

The Society that voted on October 28, 1988, to apply for membership of the WPA was not the All-Union Society of Psychiatrists and Neuropathologists, but the All-Union Society of Psychiatrists and Narcologists. Not only the name of the AUSPN changed, but so did the whole Society: the Neuropathologists withdrew from the AUSPN and set up their own association, while the Narcologists joined the Psychiatrists. Therefore we asked Professor Junod, whether that allows the new society to use the telegram by the old society, or whether they have to follow all the steps again.

Professor Junod answered:

"A question has been raised regarding the change of name of the Soviet Society applying for Membership to WPA. I am not in a position to answer that question on the basis of the information made available to me, but may only indicate the rules that govern the answer:

a) either this was simply a change of name of the Soviet Society, and such a change of name is, therefore, irrelevant; in other words, the twelve month time limit provided for by clause (5) of the By-Laws should be computed from the date of the formal application filed by the new Society.

b) or this was not a change of name, but the replacement of one Society by another (under a different name); in such a case, the new Society could not have the benefit of the application previously filed by the former Society, even with the consent of the said former Society, but the twelve month notice provided for by clause (5) of the ByLaws should be computed from the date of the formal application filed by the new Society."

3. The rights of members of the Executive Committee

In Documents no.19 we reported that the All-Union Society sent the documents required by the WPA regulations only in March 1989 and that Professor Schulsinger, the General Secretary of the WPA, reportedly refused to show these papers to other members of the Executive Committee. Therefore we asked Professor Junod whether all the members of the Executive Committee have the right to see all incoming documents, or whether the General Secretary can refuse members of the Executive Committee to see papers.

Professor Junod answered:

"Even though the Statutes and By-Laws of WPA do not contain any specific provision in that respect, it is quite clear that all the members of the Executive Committee have the right to see all documents addressed to WPA, and expecially all documents relating to matters submitted to the Executive Committee in accordance with the Statutes or By-Laws of WPA. It would therefore be illegal for the Secretary General of WPA to deny the right of access of Members of the Executive Committee to such documents."

4. The unsigned application

As reported in Documents 19, Professor Zharikov of the AUSPN was asked to sign the papers regarding their application for membership of the WPA one day after the Executive Committee voted on provisional membership for the Soviet All-Union Society. That means, that the Executive Committee voted on basis of an unsigned document. We asked Professor Junod whether an Executive Committee can vote on an unsigned document/application?

Professor Junod answered:

"As indicated above, an application for Membership of WPA must be unequivocal. This certainly implies that it must be validly signed on behalf of the applicant Society. This rule must, however, not be construed too narrowly; therefore, to the extent that a formal application is "accompanied by a copy of the Resolution

passed by the Society in request of WPA Membership", it would be quite acceptable, if such application consisted in, e.g., a telex or telefax, that the signed original document would be received by the Secretary General or the Executive Committee of WPA only later. Any decision made by the Executive Committee on the basis of the telegram, telex or telefax should be regarded as conditional; upon receiving the signed document.

Changing the Statutes and ByLaws

As reported in Documents 19, in October 1989 the General Assembly of the WPA in Athens will vote on the proposed new Statutes and ByLaws. By introducing an extraordinary General Assembly, to take place on October 11, many regulations regarding an ordinary General Assembly are evaded. For instance, it will be no problem to change the sequence of the agenda, which otherwise (if it were an ordinary General Assembly) would need to have a set sequence. This means, that the new Statutes and By-Laws could be put to the vote first, which would change the voting-system if it is adopted, and then one could proceed with the applications of new member-associations either during the extraordinary General Assembly or during the ordinary one, a few days later.
In Documents 20 we wrote, that "it seems some members of the Executive Committee (the "Executive" within the Executive Committee) plan to propose the new Statutes and By-Laws not as new Statutes and By-Laws, but as amendments to the Statutes and By-Laws. They hope that thereby the changes will have effect immediately, and that voting regarding applications of new societies can so take place on basis of the new voting structure. It is clear that this new voting structure would sharply increase the chances for the AUSPN to get full membership."

We therefore asked Professor Junod, whether amendments to the Statutes and By-Laws will be in effect immediately after they have been voted upon, or whether they first should be registered. We also asked whether the sequence of the agenda of the General Assembly can be changed.

Professor Junod answered as follows:

"Amendments to the Statutes and/or By-Laws of WPA are in effect immediately after they have been adopted in accordance with item 30, respectively item 3 of the Statutes. In the case of WPA, registration with the Geneva Trade Register is purely optional (see Article 61 paragraph 2 of the Swiss Civil Code), and even if it were not purely optional, registration would be of a purely declaratory nature. Of course, the immediate effect of such amendments is subject to judicial review in accordance with Article 75 of the Swiss Civil Code, as a result of a legal action initiated by a member of the Association. Such action must be brought within one month from the day when the member of the Association has received knowledge of the decision (amendment) which

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he considers illegal. If his action is accepted, the Court decision would have effect ex tunc, and any decision made on the basis of the amendment that has been declared illegal would also be null and void.

Once it has been adopted in accordance with clause (9) of the By-Laws, the Agenda of the General Assembly of WPA cannot be amended, either by the Executive Committee or by the Assembly itself (except with the consent of all members of WPA, including those who do not attend the General ASsembly in question). Any decision made on an item that does not appear on the Agenda adopted in accordance with clause (9) of the By-Laws would be illegal and would, therefore, be declared null and void by the Court in accordance with Article 75 of the Swiss Civil Code."

Can the All-Union Societ vote?

An important question is, whether the All-Union Society as a provisional member will have the right to vote or to propose candidates for offices within the WPA?

Professor Junod answered:

"In accordance with clause (5) of the By-Laws of WPA, an Applicant Society whose application has been accepted by the Executive Committee is granted "ad hoc", i.e. provisional Membership, until tho Executive Committee's decision is confirmed (or reversed) by the General Assembly. The question has been raised as to whether such an Applicant Society is entitled to vote at the General Assembly and/or to propose candidates for offices to be elected by the Assembly. The first question is not solved by the Statutes or By-Laws of WPA. In my view, it must clearly be solved in the negative, at least insofar as the vote relating to the admission of the Applicant Society in concerned. This is also implied by clause (10) of the By-Laws, whereby "the President shall first request the General Assembly to vote on the application on new Societies". Any Applicant Society whose Membership has been confirmed by the General Assembly is, immediately thereafter, entitled to vote on all the other items appearing on the Agenda of the General Assembly. In view of the said clause (10) of the By-Laws of WPA, the second question does not actually arise, as such votes would come up later on the Agenda of the General Assembly."

This last point means, that the All-Union Society, if accepted as full member, will have the right to vote on candidates for the next Executive Committee. Their thirty votes could help certain psychiatrists, who helped them to rejoin the WPA, to get (re-)elected to the Executive Committee of the WPA.

Robert van Voren,
General Secretary.

Liste der politischen Gefangenen in psychiatrischen Einrichtungen in der UdSSR

Stand 26.06.1989

USSR News Brief
Das Land und die Welt e.V.
Schwanthalerstr. 73/V
D-8000 München 2
Tel. 089/53 05 14

(?) ANTIPOV Igor
Art. 64
PH: 142370, Moskovskaya obl., Chekhovsky r-n, st. Stolbovaya, s. Troitskoye-Antropovo, gorodskaya PB No. 5

(?) BATULIN
Arrested beginning of 1986
Art. 70
From Kiev
PH (?)

(?) BOGDZEVICH Vyacheslav Yurievich, b. 1958, physician
Arrested 10.07.1985
Art. 70 (?). Links with NTS
Father Bogdzevich Yury Genrikhovich: Volgograd, pr. Lenina, 48/2, kv. 57, tel. 344 980
PH or SPH

BORSNIKOV Sergei, b. 1955-1960
Arrested 17.09.1987
Art. 83 (?). Attempt to cross the Romanian border
Dnepropetrovsk SPH, 3 otdelenye

BUZHENKO Sergei, b. 1957
Arrested before 1981
Art. 190-1
Dnepropetrovsk SPH

(?) CHISTKOV Viktor Ivanovich, b. c. 1948
Arrested 1969
Art. 83. Attempt to escape to the USA through Mongolia and China
From Oryol region
Became mentally ill in SPH
PH (?)

(?) CHOKHISAM Vladimir Viktorovich, b. 1947
Arrested beginning of 1985
Art. 206 p. 2
Previously: 1980-1985, Art. 190-1 and others
Mother Chokhisam Yekaterina Ivanovna: g. Ivanovo, ul. Dianovykh, 14, kv. 42, tel. 372 66
PH: 155600, Ivanovskaya obl., g. Shuya, ul. Soyuznaya, 15, PB, 2 otdelenye

DENISOV Yevgeny, archeologist
Arrested not later than 1985
Tried to collect signatures in protest of the war in Afghanistan
From Dushanbe
Disabled
PH: 735400, TadzhSSR, g. Ordzhonikidzeabad, pos. Kaktash

FADEYEV Nikolai, soldier
Arrested 1979
Escaped to Turkey, was handed over by Turkish authorities to USSR
From g. Kemerovo
Dnepropetrovsk SPH

(?) GLUKHOV Yury, b. 18.10.1939, worker in a sewing factory
Arrested 10.09.1985
Art. 70. Wrote critical letters to Soviet institutions
PH: Moskovskaya obl., g. Abramtsevo, oblastnaya PB no. 5

GOGIASHVILI Georgy, b. c. 1930, engineer
Arrested 1985
Art. 70
From g. Rustavi, GruzSSR
Oryol SPH

GROMOV Leonid Nikolayevich, b. 03.08.1963, metal worker photo 5
Arrested 22.02.1985
Art. 98 p. 2. Burned technical and arms equipment and documentations prepared to be sent to Afghanistan and Nicaragua
Tried December 1985
Parents Gromov Nikolai Fyodorovich, Gromova Valentina Leonidovna (divorced): 432007, g. Ulyanovsk, ul. Minina, 23, kv. 7
Prostatitis, endocrinological illness, stomach ulcer, possibly was taken mentally ill in SPH
PH: g. Ulyanovsk, pos. Karamzina, 1-ya oblastnaya PB im. Karamzina, 10 otdelenye

GYURDZHYAN Alexander Ilyich, b. 1947
Arrested 1975
Art. 190-1. Attempted to found a party of "Young communists"
From g. Baku
Mentally ill
PH: AzSSR, Baku, pos. Mashtaga, 20 otdelenye

(?) IVANOV Anatoly
Arrested before 1977
Art. 70
Was taken mentally ill in PH
Rostov SPH

(?) KALISHIN Andrei S., b. 1955, engineer
Arrested January 1979
Arts. 68, 196, 218, 206 p. 2. Blew self-made devices in Kuibyshev at a military registration office and a statue of the minister of defence
Tried 7-10.12.1979. Tried with him: I. Izvekov
Parents, wife: 443100, g. Kuibyshev, ul. Molodogvardeiskaya, 225, kv. 39
Kazan SPH

KALYUZHNY Vladimir Dmitrievich, b. 24.05.1951 photo 8
Hospitalised February 1988
(Sought to emigrate to the FRG)
Previously: 1975-87, PH for attempting to escape to Afghanistan
Wife Babarika Lidiya Timofeyevna: 340055, UkrSSR, g. Donetsk, ul. 50-letiya SSSR, 140, kv. 4
PH: 340000, UkrSSR, g. Donetsk, gorodskaya PNB No. 2

KONOVALOV Yury Ivanovich, b. 1935, physician
Arrested December 1981
Art. 190-1. Exposed abuses in Soviet top administration
From Moscow
PH: 142370, Moskovskaya obl., Chekhovsky r-n, st. Stolbovaya, s. Troitskoye-Antropovo, gorodskaya PB No. 5

(?) KORSAKOV Klim Alexandrovich
Art. 64
PH: 142370, Moskovskaya obl., Chekhovsky r-n, st. Stolbovaya, s. Troitskoye-Antropovo, gorodskaya PB No. 5

KOZHIN Vladimir Vladimirovich
Arrested 1984
Art. 206 p. 2. (Circulated leaflets calling for resignation of K. Chernenko)
From Minsk
Mogilev SPH, 1 otdeleniye

(?) KOZLOV Vitaly, b. c. 1935, worker
Arrested 1973
Art. 64. Attempted to obtain political asylum in Argentinian embassy
Previously: 1956-?, SPH, Art. 58 of the old Criminal Code
From Moscow
Was taken mentally ill in SPH (?)
Kazan SPH

KUBYSHKIN Vasiliy Pavlovich, b. 1920, worker
Arrested c. 1975
Art. 70. Critical statements about the regime
Previously: SPH, Art. 70
From Moscow region
PH: Moskva, Stavropolskaya ul., 27, gorodskaya PB No. 13

(?) LASHKEVICH Nikolai
Art. 190-1. Wrote leaflets with poems
From g. Bryansk
PH: g. Bryansk, ul. Saltykova-Shchedrina, OPNB No. 3, 5 otdelenye

LEONOV
Art. 70
Oryol SPH

LUBENTSOV Alexander
Art. 190-1. Made xerox copies of "anti-soviet" leaflets
From g. Sverdlovsk
Volgograd SPH, 7 otdelenye

(?) MAXIMOV Boris Arsentievich
Arts. 64, 170, 175
PH: 142370, Moskovskaya obl., Chekhovsky r-n, st. Stolbovaya,
s. Troitsko-Antropovo, gorodskaya PB No. 5, 19 otdelenye

MOLOKANOV Yevgeny, b. 1963
Attempt illegally to cross the border
PH: g. Dzhambul, KazSSR

(?) MULTINS Vitolds Yanovich
Arrested 1984
Art. 190-1
Family: 228400, LatvSSR, Daugavpils, Kaunas iela, 74-26
PH: 228400, LatvSSR, Daugavpils, L.Darza iela, 62, respublikanskaya PB

(?) NABOKIN, agronomist
Arrested before 1982
Circulated about 1000 political letters
From g. Orenburg
PH

(?) NEDELIN Ye., b. 1924
Arrested 1983
Art. 70
Wife, 2 children: g. Krasnodar
PH (?)

NEKREDIN Yury, b. c. 1950
Arrested before 1983
Attempt to get into US embassy
From g. Nalchik, Kabardino-Balkarskaya ASSR
Was taken mentally ill in PH (?)
Leningrad SPH

(?) NIKITENKOV Vasily Nikolayevich, b. 1928, physician
Arrested 30.09.1979
Art. 190-1 (?)
Previously: 1971-75, Art. 70, PH and SPH
Wife Nikitenkova Lyubov Prokopievna, daughters (b. 1962, 1966):
141611, Moskovskaya obl., g. Klin, ul. K. Marxa, 88, kv. 68
Mentally ill
PB: Moskovskaya obl., st. Stolbovaya, gorodskaya PB No. 2

OBYEKTOV Yevgeny Mikhailovich, b. 1953
Arrested September 1986
Attempt to escape to Turkey through the Black Sea on a rubber boat
PH (?)

OGANESYAN Varoz Solomonovich, b. 1928, physicist
Arrested 1969
(Exposed abuses on a party conference)
From Yerevan
PH: 375071, Yerevan, r-n Sovetashen, respublikanskaya PB

OLEINIKOV Yury, b. 1954, political officer
Arrested 1983. 10 str. Rel. 1993
Art. 64. Attempt to escape to Turkey
From g. Kuibyshev
Was taken mentally ill in camp
Kostroma SPH

PAVLOV Alexei M.
Arrested before 1967
Art. 83
From Moscow (?)
Was taken mentally ill in SPH
PH: Moskovskaya obl., g. Abramtsevo, oblastnaya PB no. 5

(?) PETROV Yury
Arrested before 1979
Attempt to hijack an aeroplane
Chernyakhovsk SPH (?)

(?) POTAPOV Yakov Mikhailovich, Candidate of Medical Sciences, physician
Art. 70
From g. Sverdlovsk
PH: g. Sverdlovsk
(?) POZHARSKY, b. 1951
Art. 70
Oryol SPH

(?) REVYAKIN Mikhail
Art. 70
Previously: Several times imprisoned under Art. 70 and criminal arts.
From g. Mivhurinsk, tambovskaya obl.
PH

(?) SIDOROV Valery, b. 1955 or 1956, electrician
Arrested 1984
Art. 70. Circulated leaflets, wrote poems
From g. Plavsk, Tula region
Oryol SPH

STEBA Ivan Makarovich, b. 1926
Arrested not later than 1967
Art. 70. Criticised living conditions in the USSR, intended to be repatriated to relatives in Australia
Wife, 2 sons
PH: 250005, UkrSSR, g. Chernigov, ul. Shchorsa, 3, oblastnaya PB, 7 otdelenye

(?) STEIN Lyubov Yakovlevna, b. 1949
Arrested 1971
Art. 64. Attempt to escape to the West through Czechoslovakia
PH: g. Kirov, oblastnaya PB (?)

STYSHCHUK Konstantin Nikolayevich, b. c. 1920
Arrested not later than 1983
Art. 190-1
From g. Ivano-Frankovsk, UkrSSR
PH: UkrSSR, g. Ivano-Frankovsk

SUDAKOV Stanislav Grigorievich, b. 09.02.1945
Arrested 1974
Attempted to get into US embassy
Mother Vorokhova Sofya Nikolayevna: 320033, UkrSSR, g. Dnepropetrovsk, ul. Pobedy, 206, kv. 2, tel. 96 71 24
Was taken mentally ill in SPH
Leningrad SPH

SUKHAREVICH Franz Franzevich, b. 1937
Art. 64
From Sverdlovsk
PH: g. Sverdlovsk, oblastnaya PB

(?) VINOGRADOV Valentin, b. 1947, history teacher
Arrested beginning of 1983
Links with NTS
Address before arrest: Leningrad, ul. Prazhskaya, 33, kv. 70
PH or SPH

(?) VORONOV Nikolai Pavlovich, artist
Arrested before 1978
Art. 190-1
From Perm
PH (?)

(?) ZHUK Anatoly, b. 1963
Hospitalised May 1988
Pacifist, refused call-up for military service
From g. Grozny, Checheno-Ingushskaya ASSR
PH: Leningrad

Soviet Psychiatry Diagnosed by Reformers as Ailing

WASHINGTON POST 7/1/89

By Michael Dobbs
Washington Post Foreign Service

MOSCOW, June 30—Retired forestry worker Yuri Sobolev was committed to a mental asylum in March. His symptoms: heckling the local Communist Party boss at a preelection meeting and harboring "extremist ideas."

Such things are not meant to happen in Mikhail Gorbachev's Soviet Union. Last year, the country's highest state body adopted a decree ostensibly designed to put an end to the practice of locking up political dissenters in psychiatric hospitals. Sobolev's case shows that old habits die hard.

According to the government newspaper Izvestia, a local doctor in the Ulyanovsk region on the Volga River diagnosed Sobolev as mentally ill without even meeting "the patient." The story described Sobolev, who later escaped from the mental hospital, as perfectly sane.

The past few weeks have witnessed a sudden spate of articles in progressive Soviet journals and newspapers focusing attention on continuing abuses of psychiatry for political purposes. Several articles have suggested that radical reforms in Soviet psychiatry will not be possible without the dismissal of doctors and theoreticians who have dominated the profession for the past two decades.

The controversy that has erupted in the Soviet press reflects a struggle between the old guard that still dominates Soviet psychiatry and reformers who want a complete break with past practices. Both groups appear to have their patrons within the political leadership.

"There is a strand of opinion within the leadership that believes that you will never get *perestroika* [reform] in Soviet psychiatry without a turnover of the leading personnel. There is also a rather weak reformist element within the psychiatric community. These two groups work together. When the political climate is good, you see articles in the press denouncing abuses," said Peter Reddaway, a leading Western expert on Soviet psychiatry.

The progressive Literaturnaya Gazeta this week named leading Soviet psychiatrists who, the paper said, were responsible for past abuses. The doctors included Georgy Morozov, head of Moscow's Serbsky Institute for the past 30 years and the most powerful individual in Soviet psychiatry; Marat Vartanyan, head of the Soviet Center for Psychiatric Health, and Albert Churkin, chief psychiatrist for the Soviet Health Ministry.

"A vast number of facts that have been uncovered of violations in psychiatry and its use for political purposes testifies to the guilt of the leaders of this branch of medicine. It was with their agreement that healthy people were sent to psychiatric hospitals," wrote Leonid Zagalsky, a reporter for Literaturnaya Gazeta.

Several of the doctors named in the article held meetings with a team of American psychiatrists who were given unprecedented access to Soviet mental institutions in March. The U.S. psychiatrists are to submit a report on their findings on July 12 to a congressional committee reviewing Soviet compliance with the human rights provisions of the 1975 Helsinki declaration.

The Soviet Union withdrew from the World Psychiatric Association in 1983, rather than face expulsion in the face of international condemnation. An application for readmission is under consideration by the association, a step that would effectively remove a major blemish on the Kremlin's human rights record.

Independent U.S. and Soviet experts acknowledge that Soviet psychiatry has improved over the past few years and that many dissidents have been released from mental institutions. But they also argue that there are no guarantees preventing the recurrence of abuses, either locally or on a wide scale.

The Sobolev case is a perfect illustration of a mechanism that allows local officials to remove troublemakers from circulation. According to Izvestia, Sobolev had already spent 18 months in a psychiatric hospital several years ago because of his unorthodox views. His attempts to seek redress for illegal confinement were regarded by the authorities as further evidence of mental instability.

"He has become suspicious, harbors extremist ideas of a change in power, is preparing for a coup, and writes to all sorts of offices," wrote Dr. Vladimir Kamalov in his official report, diagnosing Sobolev as having a "reactive psychosis" and "depreserve-paranoid syndrome."

Izvestia's investigation showed that Kamalov ordered Sobolev sent to a psychiatric hospital after a telephone call from the local militia chief. The militia chief, Alexander Loginov, told the newspaper that he had been contacted by the secretary of the local party committee, Vitaly Panasenko, who told him "to get Sobolev out of the way."

The Izvestia reporter said that he was unable to establish whether Panasenko was acting on his initiative or under instructions from someone else. The official candidate in the elections was the Ulyanovsk regional Communist Party chief, Yuri Samsonov, the top local leader.

A decree issued by the presidium of the Supreme Soviet last year transferred control of "special psychiatric hospitals," previously used for the incarceration of dissidents, from the Ministry of Interior to the Ministry of Health. But this week's Literaturnaya Gazeta article maintained that the "good intentions" of the Supreme Soviet resolution have been undermined by detailed regulations issued by the Health Ministry.

Literaturnaya Gazeta said the Health Ministry regulations failed to guarantee Soviet citizens protection against unlawful incarceration. Article nine of the regulations suggests that unemployment, material insecurity, lack of a fixed place of abode, family conflicts and "susceptibility to social influence" can all be signs of "social maladjustment."

"Judging by this article, any citizen of our vast country could become a patient in a mental hospital," the newspaper said.

The Literaturnaya Gazeta article cited the case of a lecturer at a Leningrad naval college who was sent to a mental asylum after he wrote an article pointing out a technical error in the economic theory of Karl Marx. He has since been rehabilitated, but the psychiatrist involved in the case, identified as G.I. Mishin, appears to have no regrets.

Asked whether the lecturer was mentally ill, Mishin reportedly replied, "Of course he is. He disagrees with Marx."

NEW YORK REVIEW OF BOOKS, February 1989

Another Betrayal by Psychiatry?

I. F. Stone

Seventeen years ago I attacked the World Psychiatric Association in these pages in "Betrayal by Psychiatry"[1] for refusing to hear complaints from Soviet dissidents, including Andrei Sakharov, about the political abuse of psychiatry in the Soviet Union. The WPA staged a repeat performance a few weeks ago at a regional meeting here in Washington.

The WPA leadership turned down a request from Western and Soviet activists to present a symposium on "Soviet Psychiatry in the Gorbachev Era." The centerpiece of that symposium was to have been the poignant videotaped message by Alexander Podrabinek that was smuggled out of Moscow and published in the December 8 issue of *The New York Review*. The WPA leadership is anxious to get the official Soviet psychiatric organization back into the WPA. It is apparently willing to do so without first eliciting firm assurances from the Soviet authorities that past abuses will not recur.

A symposium on "Soviet Psychiatry in the Gorbachev Era" could have provided an opportunity to invite the Soviets to hear an independent assessment of recent changes, to clear the air of fresh complaints, to present their side of the story, and open the way for their readmission. That would be glasnost in action. But official Soviet psychiatrists and their Western allies are in no mood for such a cleansing dialectic. The Soviets want readmission on their own terms, without conditions.

As a result the delegates to the regional conference did not get a chance to hear for themselves what experts on Soviet psychiatry had to say. They were able to present their views only in an unofficial meeting arranged by the International Association on the Political Use of Psychiatry on a late Friday afternoon. Only a minority of the conference participants were present, and except for full coverage by West German television, it attracted meager attention in the press. The only story I saw about the symposium was in *The New York Times* (Sunday, October 16), which failed to report that the WPA leadership had refused to permit the discussion to be held at the regional meeting, when all the delegates could more easily have heard it.

Other participants in the symposium included Peter Reddaway of the Kennan Institute, Dr. Sidney Levine from the Royal College of Psychiatrists in Great Britain, Robert van Voren from the International Association on the Political Abuse of Psychiatry with headquarters in Holland, Paul Chodoff of the American Psychiatric Association, and Dr. Anatoly Koryagin, the Soviet psychiatrist who dared to expose Soviet abuses and was first jailed and then expelled from the USSR. All expressed misgivings about the reluctant pace of Soviet reform and the refusal of the Soviet authorities to admit that the political abuse of psychiatry against political dissenters had ever occurred, let alone to condemn the practice. Their criticism was reinforced by Dr. Sakharov's complaint on his recent visit to the US that dissidents were still being held in psychiatric hospitals.

In addition to the WPA's foray into protective censorship, its leaders, including a key committee chairman from East Germany, have set in motion a plan to amend its voting procedures to make it easier for the Soviets to reenter the WPA without facing a fresh debate on past—and present—abuses.

The excuse for its rejection of the symposium given by the WPA to the American Psychiatric Association, which was the host for the regional meeting and was anxious for the symposium to be heard, was that "the symposium has a content that is well known to everybody. The content is hardly scientific and it will not serve to promote international collaboration." But Michael Gordon of *The New York Times* drew a more succinct and candid explanation from Dr. Costas Stefanis, the Greek professor of psychiatry who is president of the WPA. Dr. Stefanis said his organization "must be careful not to interfere in the Soviet Union's internal affairs." This standard would nullify the UN's Universal Declaration of Human Rights and the Helsinki accords. It is the same reply South Africa gives to critics of apartheid.

Dr. Stefanis said the Soviet psychiatric association had expressed its "willingness to apply" for readmission in the WPA. But he did not say whether this willingness was subject to the same conditions laid down by Alexander Churkin, chief psychiatrist of the Soviet Ministry of Health, at a press conference in Moscow last February. "We are ready to come back," Dr. Churkin said, "provided the executive board and the association will be a working atmosphere and political activity will not be discussed there" (*The Washington Post*, February 12, 1988).

In other words the Soviets want guarantees of protection from further criticism. The West, not Moscow, must "reform." This is glasnost glazed over. The political abuse of psychiatry is to be declared out of bounds because it is political! The Hippocratic oath made the physician swear that "the regimen I adopt will be for the benefit of my patients... and not for their hurt or any wrong." Neither Greek tyrants nor Roman emperors ever ventured to suggest amending it to read, "unless so ordered by political authority." Indeed at one point in current negotiations between Moscow and the State Department for an exchange of "visits of inspection" between US and Soviet psychiatrists, Moscow refused to accept any official delegation from the American Psychiatric Association unless it first apologized for its past criticism of Soviet psychiatric abuses.

World opinion should be on guard against current Soviet reassurances. One of the reforms promised is the transfer of the notorious "special psychiatric hospitals"—like the dreaded Serbsky Institute—from the Ministry of the Interior to the Ministry of Health. But Dr. Churkin's statements at last February's press conference did not create much confidence in this shift of jurisdiction. Dr. Churkin said that the Soviet Union withdrew from the WPA in 1983 because it had become too politicized. The whole truth, as he must know, is that in 1983 the Soviets sent to the World Psychiatric Association headquarters, then in Vienna, delegates who were prepared to discuss some specific cases. But they had hardly arrived when they were suddenly called home and the Soviets withdrew from the WPA rather than face a debate on reform.

Current doubts are reinforced by the recent "multicandidate" election for the head of the All Union Society of Psychiatrists, the main Soviet psychiatric organization. According to the recent reforms, multicandidate elections are supposed to democratize one-party rule. But the three candidates—in a carefully orchestrated system of indirect voting—were Drs. Georgi Morozov, Marat Vartanyan, and Nikolai Zharikov, all of whom were long associated with the late Dr. Andrei V. Snezhnevsky, who made Soviet psychiatry a complaisant tool of the KGB. More recently, under glasnost, the Soviet press had itself begun to open up on Soviet psychiatric abuses. But it has never directly discussed the forbidden topics of psychiatric mistreatment of dissidents. The nearest thing to such an admission occurred at the same February press conference. Dr. Modest Kabanov, a psychiatrist from Leningrad, which has generally been more liberal than Moscow in psychiatric matters, then acknowledged that in the past some doctors had sent people to mental institutions for reading authors frowned upon by the political authorities. He cited two such writers—Bulgakov and Pasternak.

Dr. Kabanov said, "Of course such mistakes will not be repeated." But nothing was said about legal reforms that might prevent such travesties of psychiatry from being repeated.

The abuse of psychiatry seems to be a major grievance in the flood of complaining letters to the editor evoked by the promise of glasnost. Even a cursory sampling of the "Current Digest of the Soviet Press" and the US Foreign Broad-

[1] *The New York Review*, February 10, 1972.

LETTER TO WESTERN COLLEAGUES

by Dr.Semyon Glusman, Kiev

Dear Colleagues,

Good and evil most often have the same color: grey. The color of ordinariness. From there come the self-deception, hopes and disbelief. Especially at a distance, when the haze softens the contours of the face and appearance. Deficiencies can be seen from a direct, close view; a richness of crevices and spots is accentuated in detail. I am nearby. In the middle of it. But I will try to be objective in looking at the image.

The past and the present of our psychiatry is well-known. It could not have been different, the system of totalitarianism excludes alternative development and the existence of its branches... Today I am reflecting on something else, on the future.

We are at the beginning of the journey (or at the end? But then there is a lot, including this letter, that makes no sense at all). We are learning to know the truth about ourselves, to speak it out. It is a difficult exercise for a country, that has no democratic tradition, no tradition of justice; for a country, where an important part of the population are slaves of, or subordinates to the System. The workers are slaves, the farmers are slaves, the writers are slaves, the doctors are slaves, the bosses are slaves.

The System, oriented to exceptionally ideological values, has pushed aside both concrete knowledge and righteousness. Maltus and Freud, Viner and Mendel, Schweizer and Berdyayev were declared to be enemies and fools. Psychiatry, originally oriented to righteousness and compassion, was stripped of its moral and methodological bases. Here is an example of the thoughts of our "founding fathers" of today: "Psycho-analysis is a pseudo-scientific conception of psychotherapy" (Professor Rozhnov, 1987, at the symposium "Issues of methodology in psychiatry"). Psychiatry, solely oriented to ideological values, became isolated from the world association of its colleagues. There was no other way out...

What is happening today in our country is a miracle. It is unexpected, incomprehensible. But it is happening. Hopes have risen. Slowly the sick country is freeing itself from totalitarian ways of thinking, unable to self-analyze, deprived of moral tendencies. The totalitarian power, speaking for decades on behalf of the people, but in fact only acting solely on its own behalf, is alive and strong. And it resists. And the institutes of this power resist the new, the humane and the all-human. Also psychiatry resists, the stagnant, self-isolated, poor and amoral totalitarian psychiatry. While dissertations have been defended and academic grades and positions have been acquired, the conscience is blackened by the memory of personal professional abuses... How can one not resist? How can one not hate that unexpected destruction of everything which was habitual and peaceful, [a destruction which is] called "glasnost and perestroika"?

Direct opposition is senseless. Because it is dangerous.

They are not those kind of "dissidents", they know; the most important is their own welfare. They resist in a different manner, mascerading and "participating in the current policy of the Communist Party of the Soviet Union".

I don't doubt that: neither Academician Morozov, nor Academician Vartanyan wanted the changes in the country. They were happy with the status-quo. But they are small wheels, they weren't asked...

I don't doubt that: neither Morozov, nor Vartanyan want, deep in their hearts, a return of Soviet psychiatrists to the WPA. Isolation is more peaceful for them. More peaceful in all respects. Among others in connection with covering up the real value (and sometimes the author) of their "scientific achievements"...

But they are small wheels. They aren't asked. "It is necessary. We have to return to the WPA!" That's the command.

They are not the problem, these hangmen and the adventurists. The problem is you, is the WPA. Do you agree? Can you agree? Can you smile and shake the hand of a person, who personally participated in psychiatric punishments of many mentally healthy people, can you smile and shake the hands of men and women, who on basis of the suffering and despair of their mentally health fellow-citizens built their scientific and professional careers, can you smile and shake the hands of those who state today: "nothing happened, there were only individual diagnostical mistakes..." [Who state that] there was no Grigorenko, there was no Plyushch, there was no Bukovsky, there were no harrassments, beatings and deaths in Special Psychiatric Hospitals...

I understand your impatience. For people it is difficult to wait, that's the way we are; the present seems much more important and certain than the future. But the future is both the past and the present. And at present our psychiatry is, unfortunately, far from attractive. So far there is no reason to believe that the changes will definitely come.

It is a strange, Kafkaesque situation: the new leaders of the country are clearly interested in improving the situation in psychiatry, serious lawyers in very serious ideological magazines prove the insufficiency of the new normative psychiatric rules of the Ministry of Health of the USSR, the press reports more and more new facts about psychiatric abuse in the recent past (also after 1985)... and the official Soviet psychiatry lives on "in harmony and wellbeing".

It is a strange, Kafkaesque situation: in the years that the abuse of psychiatry were almost the normative practice in the administration of justice, when the highest authorities of the country harshly and openly ignored legality, economic laws and the world public opinion, the psychiatric world managed to get rid of the punitive psychiatrists. And today, when inside the USSR the problem of psychiatric abuse is open to discussion and is almost acknowledged by the authorities, the psychiatric world accepts their "Soviet colleagues" in their midsts, smiles at those who not long ago surely carried out the functions of a hangman...

Do you remember Shakespeare: "I have the feeling the world sleeps". I have the feeling that the horrendous and dreadful

dream has changed the faces of people, exchanged the faces of good and evil, of hangmen and victims. The bitter, terrible life of these unfortunate prisoners of the Special Psychiatric Hospitals of the Ministry of Internal Affairs, hasn't that been a lesson to the world? Haven't you, dear colleagues, established a "class morale"?

I don't understand. Really, I don't understand: how can one accept back in the WPA those, who tortured before and do not acknowledge it today. Don't you know that it is neither president Gorbachev, nor deputy Sakharov who you want to accept back into the WPA, but the same Morozov, Zharikov, Vartanyan? Not the thousands of ordinary Soviet psychiatrists, who saw it all, understood it all but were afraid to protest, but the fake-scientists and hangmen, the stained, those without a conscience, the incompetent ones.

The director who, sent by Hitler, performed Beethoven in Zürich, Paris or Budapest, became guilty of the most obscene lie, under the pretext that he was a musician and was involved in music and nothing else. Those are the words of Thomas Mann.
The psychiatrists, who accept in their midsts unconfessed hangmen, are guilty of a most obscene lie, under the pretext that they are psychiatrists and are busy with psychiatry and nothing else.

...There were many ways to calm one's conscience, to consider oneself innocent, to look the other way, to keep silent... In reality to all these crimes was added the attempt of many people not to know about what was happening... These are the words of Richard von Weizsäcker about Germany's past.
And how topical are they today, here in the USSR. And not only here, because many of you there today try "not to know".

Isn't that politics as well? That senseless, immoral shortsightedness, knowingly mixing things that cannot be mixed: the reforms of Gorbachev and the personal ambitions of Vartanyan, Morozov and co.?
Yes, we need contacts with psychiatrists in the civilized countries. As we need to learn. We need your textbooks, your magazines, your doubts and your insights. We have to catch up. We need your medical and judicial experience, your advice. It is us who need it, not Vartanyan, Morozov, Pechernikova, Taltse...

A morally oriented psychiatry cannot be led by people, who are oriented to completely different, conjuncturist goals.

...The situation is complex. I cannot give you any advice as to how to behave. I only know one thing for sure - how not to behave. In the past doctors were tried in Nürnberg, guilty of the deaths of thousands of mentally ill people. The conception of totalitarian psychiatry was convicted there as well.

I don't call for a trial, nor for vengeance. The most important are not the judicial procedures. On top of that hangmen usually don't recant. The thing that happened in Granada, and that can happen in Athens as well, has a name: complicity. Do you understand?

Semyon Gluzman,
Honorary Member of the American Psychiatric Association and a Distinguished Fellow of the British Royal College of Psychiatrists.
Kiev, June 18, 1989.
USSR

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July 24, 1989

Senator Dennis DeConcini
Congressman Steny H. Hoyer
Commission on Security and Cooperation in Europe
237 House Office Building Annex 2
Washington, D.C. 20515

Dear Senator DeConcini and Congressman Hoyer:

I would like to express the appreciation of the American Psychiatric Association for the hearings which you conducted on the American visit to the Soviet Union to study uses of psychiatry. We also appreciate the opportunity given to us to submit written statements for the record. Since you have a wealth of information already submitted by others, we have decided to submit this joint statement from the two of us in our respective roles regarding the Soviet Union and this delegation's visit.

We do appreciate your assistance in the inclusion of this statement in the record and hope that you won't hesitate to let us know if you need any further information. Thank you again for your ongoing interest in this important subject.

Sincerely,

Melvin Sabshin, M.D.
Medical Director

Ellen Mercer

Ellen Mercer
Director, Office of
International Affairs

JOINT STATEMENT TO THE COMMISSION ON SECURITY AND COOPERATION IN EUROPE

by

Melvin Sabshin, M.D., Medical Director, American Psychiatric Association and Associate Secretary, World Psychiatric Association

and

Ellen Mercer, Director, Office of International Affairs, American Psychiatric Association, and Member of American Delegation to USSR, February/March 1989

We are happy to have the opportunity to submit a written statement to the Commission on Security and Cooperation in Europe about the situation surrounding the American mission to the Soviet Union earlier this year and its relationship to the possible readmission of the All Union Society of Psychiatrists and Narcologists of the USSR to the World Psychiatric Association. As you know, the All Union Society received an ad hoc membership status with the World Psychiatric Association from the WPA Executive Committee at its meeting in March. One of us (Melvin Sabshin, M.D.) abstained from voting on that membership status because I preferred to wait until the results of the American delegation's visit to the Soviet Union were available and distributed. In addition, since there are resolutions pending before the WPA General Assembly citing certain stipulations which the All

Union Society might be required to meet prior to readmittance, I thought that such an ad hoc membership was premature. I hope that eventually there will be Soviet representation in the World Psychiatric Association but I believe this should happen only when conditions are right and when the concerns regarding the issues of psychiatric abuse in that country have been resolved.

There appears to be growing support in the world psychiatric community for the resolutions that have been submitted by the British and West German psychiatric associations which would allow the All Union Society to be re-admitted into the WPA under the following conditions: 1) The Authorities have disassociated themselves from the past abuses and taken effective action to prevent their repetition; and 2) All individuals detained unjustifiably in psychiatric institutions have been released. The APA Board of Trustees has voted in favor of this resolution but will also maintain some flexibility as to the possibility of submitting a separate resolution of its own in the event that the British and German resolutions meet with resistance at the General Assembly meeting in October. The APA may, for example, wish to have discussion of a resolution which would extend the ad hoc membership of the All Union Society until the next General Assembly meeting which would likely be in three years. The APA is in favor of assisting those individuals in the Soviet Union who are working toward reform of their psychiatric system and, thus, will attempt to move the World Psychiatric Association in that direction as well.

The APA Board of Trustees has also approved a resolution to be submitted for vote by the WPA General Assembly which suggests a new

Operational Instrument for the WPA Committee to Review Abuses of Psychiatry. This is a Committee that was formed after the World Congress of Psychiatry in Honolulu, Hawaii in 1977 when the Soviets were severely criticized for using psychiatry for political purposes. Unfortunately, the Soviets refused to cooperate with the Review Committee when they were members of the World Psychiatric Association until late 1982 when several responses to inquiries on specific patients were sent to the President of the WPA. Before those responses were analyzed or distributed, the All Union Society resigned from membership in the WPA. There were a number of resolutions pending before the July 1983 World Congress held in Vienna, Austria, which asked for expulsion or suspension of the All Union Society. The resignation of this Society prior to the World Congress prevented these resolutions from coming to a vote but, instead, a resolution was passed which stated that the WPA would welcome the All Union Society back into the membership of the WPA as long as there was clear evidence of the amelioration of the abuse issues in that country. The APA believes that its newly proposed version of the Operational Instrument of the Review Committee would be a step in the right direction to facilitate the work of that Committee and that it should be clear that all member societies of the WPA would be expected to cooperate with these procedures.

The results of the American visit to the Soviet Union under the auspices of the U.S. State Department and in consultation with the National Institute of Mental Health and the APA were made public at your hearings on July 12, 1989. We are basically quite pleased with the response from the Soviet side and hope that the report will be

useful in the reforms and changes that are being considered in Soviet psychiatry. We appreciate the efforts of the Ministry of Foreign Affairs and the Ministry of Health of the USSR in making this trip possible. As a member of the team which visited psychiatric hospitals in Kazan, Vilnius, Kaunas and Chernyakhovsk, one of us (Ellen Mercer) expresses appreciation for the atmosphere in which these visits were conducted. I (Ellen Mercer) would like to stress, however, my concern about the conditions in which the patients live in Kazan and Chernyakhovsk Special Psychiatric Hospitals and the lack of patients' rights which appeared evident to me. My concern is for all of the patients, not just for those who were interned for political reasons. There was clear evidence of mistreatment of patients among some of the staff in these hospitals and it is hoped that now that the Special Psychiatric Hospitals are under the jurisdiction of the Ministry of Health more money will be allocated in order to ensure that more qualified and caring staff can be hired. I realize that this transfer from the jurisdiction of the Ministry of Internal Affairs does not automatically mean that there will be an improvement in care for the patients in the Special Psychiatric Hospitals. However, it is hoped that the safeguards of patients rights which are recommended in the report will be seriously considered and that this will prevent the waste of human life and potential which was exhibited in the hospitals. When a patient can be interned for over 20 years under strict regime conditions for the crime of fighting while drunk when 18 years old, it is past time for investigation and reform.

I (Ellen Mercer) was impressed by the way in which the patients in the hospitals reacted to the American team. Not being a psychiatrist, I was unable to tell if there were any signs of mental illness in individual patients but it was evident to me that there was a certain depreciating attitude among members of the staff which might indicate that mental patients were considered to be of less importance than others - thus only to be monitored and controlled rather than helped. This may also be the case when it comes to the psychiatric register. Organizations around the world have worked for years to encourage the release of political prisoners from psychiatric hospitals in the Soviet Union and now may be the time to turn some of that focus on having names taken off of the psychiatric register.

We hope that there will be a serious effort in the Soviet Union to increase the public's awareness about the mentally ill and to decrease the stigma attached to this type of illness. We hope that there will be a dramatic increase in patient's rights in the Soviet Union and that patients and the general public will be educated about these rights and encouraged to take appropriate advantage of them. We hope that if there are mentally healthy people in psychiatric hospitals in the Soviet Union, they will released as soon as possible and not kept on the psychiatric register. We hope that psychiatry in the Soviet Union will increasingly be perceived as a profession used for healing purposes rather than for punitive purposes. We hope that there will be ongoing possibilities for review of certain psychiatric practices in the Soviet Union and that any alleged abuses will, in fact, be investigated. We hope that the Soviet Union will never again use the

profession of psychiatry for abusive purposes. These are some of our hopes for Soviet psychiatry as well as our hopes for psychiatry in all countries around the world, including our own.

The report of the American delegation is a valuable background document which will hopefully be used by many organizations around the world. It should be viewed, however, as part of an ongoing process which began in the early 1970's and will continue until the abuse of psychiatry comes to an end. Many organizations and individuals around the world have contributed to this process and will continue to work on these issues in the future.

We hope that more individual psychiatrists in the Soviet Union will have an opportunity to collaborate with their colleagues in other countries, including the United States, and that efforts will be made to work with psychiatrists in all parts of the Soviet Union. There is much that we can learn from each other.

* * *

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1847

12 June 1989

Ms. Dana Crosby
Helsinki Commission
Room 237
House Annex II
Washington, D.C. 20515

Dear Ms. Crosby:

Based on my experience visiting the Soviet Union and speaking with Soviet psychiatrists prior to the recent U.S. Government sponsored trip to examine alleged victims of psychiatric abuse, I have been favorably impressed that some increased openness is indeed occurring. I personally believe that the best way to further open up the Soviet Union is to encourage its increased interaction with psychiatric societies in other countries. In part because the Soviets have been excluded from the international psychiatric community (as well as for a variety of political reasons), Soviet psychiatry is very outdated. Their standard of practice and scientific knowledge is roughly equivalent to that prevailing in the rest of the world during during the 1940s and 1950s. Soviet psychiatrists have had limited access to American and European scientific journals and research. They have had little opportunity to attend international meetings. They need increased contact and exchange in order to update their level of knowledge, science, and clinical care. I am quite sure that the rather outdated level of care currently provided in the Soviet Union, and its impact on the treatment of victims of psychiatric abuse, will be detailed extensively by Drs. Roth and Regier.

I am enclosing a copy of the paper that I delivered at the end of our visit, which summarizes the American concepts of schizophrenia.

Best wishes,

Yours sincerely,

Nancy C. Andreasen, M.D.
Professor of Psychiatry

NCA:mas
Enclosure

cc: Dennis DeConcini
Steny H. Hoyer

THE AMERICAN CONCEPT OF SCHIZOPHRENIA

Nancy C. Andreasen, M.D., Ph.D.

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This research was supported in part by NIMH Grants MH31593, MH40856, and MH 43271; the Nellie Bell Trust Research Fund, Iowa State Bank & Trust Company, Trustee; and a Research Scientist Award, MH00625

The American concept of schizophrenia cannot be summarized simply, because the concept has changed and evolved since its development at the beginning of this century. Not only has it changed over time, but it has changed spatially as well, with the boundaries of the concept expanding and contracting and subsequently expanding again. These changes have occurred because the concept of schizophrenia has continuously been studied and reassessed in the light of new developments in research and clinical care. Until we have captured the complexity of schizophrenia by defining its pathophysiology and etiology (which are probably multiple, just as schizophrenia itself is probably a heterogeneous *group* of disorders), the concept of schizophrenia is likely to continue to be changed and revised as new information and insights emerge. Thus, when we speak of the *current* American concept of schizophrenia, it must be seen as dynamic and evolving, best understood in the context of both the past and the future as well as the present.

HISTORICAL BACKGROUND

The current American concept of schizophrenia must also be seen in the context of the American approach to nosology in general. Prior to World War II there was no national nosology in the United States, although preliminary attempts to develop one had begun. The World War II experience, which brought together psychiatrists from all over the United States from a diversity of backgrounds, made it clear that a common language was needed in order to achieve consistency in diagnostic thinking and to facilitate communication. The Veterans Administration took the initiative after the War and developed the first standard national nosology. Veterans' hospitals represent only a subset of

patients and physicians, however, and so subsequently the American Psychiatric Association convened a group of leading clinicians who formulated a standard national nomenclature in 1952, called the Diagnostic and Statistical Manual of the American Psychiatric Association (now referred to as DSM-I). This was revised in 1968 in order to make the American system as similar as possible to the International Classification of Diseases (ICD), leading to DSM-II. DSM-III, published in 1980, represented a major revision, since it attempted to base changes on empirical research data and introduced diagnostic criteria. DSM-III has been influential world-wide; it typically provides the nomenclature for international scientific research, since it has introduced objectivity and precision to the diagnostic process through the development of diagnostic criteria. Relatively minor changes were made in its subsequent revision, DSM-IIIR. A more comprehensive review, again based on scrutiny of empirical research data whenever possible, and also attempting to harmonize as well as possible with ICD-10, will appear as DSM-IV in 1992 or 1993.

Thus, the post-war American approach to nosology incorporates a number of characteristics that also shape the American concept of schizophrenia: regular and periodic review that has often led to modification and change in response to new knowledge, a central national system that seeks to achieve uniformity and consistency, the development with DSM-III of an emphasis on objectivity and precision, a system designed to serve both clinicians and researchers, and a conviction that judgments about nosology should be based on empirical research data whenever possible.

Prior to World War II, the concept of schizophrenia was relatively narrow. The major responsibility for the care of the seriously mentally ill was in the hands of hospital psychiatrists. Their orientation was largely Germanic, influenced at least partially by the Munich school of Kraepelin, the group that first developed

the concept of schizophrenia by delimiting it from manic-depressive psychosis (1919,1921). This construct of schizophrenia stressed that it was a severe chronic psychotic illness leading to deterioration. The concepts of schizophrenia that have evolved after World War II and were embodied in DSM-I and II were heavily influenced by the thinking of Eugen Bleuler. An English translation of his book, Dementia Praecox or the Group of Schizophrenias, appeared in 1950 and was widely read.

Bleuler took a much broader view of schizophrenia than Kraepelin. Consequently, the American concept began to broaden. The interest in Bleulerian thinking coincided with another important development in American psychiatry, the growing interest in psychoanalysis and psychodynamic thinking that occurred after World War II. As a consequence, the province of psychiatry in general broadened, as psychiatrists began to treat more and more outpatients and to try to assist patients with relatively milder conditions ranging from neuroses to problems in daily living. Psychodynamic thinking was applied to psychosis as well, as psychiatrists attempted to interpret the bizarre "primary process thinking" that they saw in psychotic patients. The boundaries of schizophrenia expanded to include Bleuler's nonpsychotic simple schizophrenia, Kasanin's schizoaffective disorder (1933), Hoch and Polatin's pseudoneurotic schizophrenia (1949), good-prognosis schizophrenia, and even latent schizophrenia (Stephens, 1966,1978; Vailliant, 1962, 1964; McCabe, 1976; Langfeldt, 1956). Because Bleuler had emphasized that psychotic symptoms such as delusions and hallucinations were not "fundamental," but rather simply "accessory," nonpsychotic symptoms became the defining features of schizophrenia: Bleuler's "four As" (associative loosening, affective blunting, ambivalence, and autism) were more or less consistently agreed on as hallmarks of schizophrenia. Since most of these symptoms are on a continuum

with normality, it was easy for at least some clinicians to see "a touch of schizophrenia" in many oftheir patients.

THE INFLUENCE OF RESEARCH

While the majority of American psychiatrists were exploring psychodynamic thinking in the 1950s and 1960s, however, other perspectives were also beginning to emerge. British psychiatry, rooted in national philosophical traditions of empiricism as well as Germanic phenomenology, began to stress the importance of defining symptoms and disorders as objectively as possible. A spate of articles were written stressing the poor reliability of psychiatric diagnoses (Krietman et al, 1961; Beck et al, 1962; Sandifer et al, 1964, 1968). These criticisms were obviously sound and had to be taken seriously.

An interest in determining the nature, severity, and outcome of schizophrenia in a worldwide setting led to the development of the International Pilot Study of Schizophrenia (IPSS) and later the US-UK Study (Wing, 1974; Kendell et al, 1971). Multi-center collaborative research can be very useful for increasing sample sizes and enhancing diversity of perspective, but when well done, it also necessitates the design of standardized assessment instruments. The IPSS led, as one of its major spin-offs, to the development of the Present State Examination (PSE) and to a computerized system for making diagnoses (CATEGO) (Wing, Wing et al, 1970, 1974, 1975). For the first time, standard descriptions of symptoms and definitions of disorders were available internationally.

The content and emphasis of the PSE, developed largely by John Wing and others at the Maudsley in London, placed strong emphasis on the importance of an alternative to the Bleulerian approach: the first rank symptoms of Kurt Schneider (Schneider, 1959; Mellor, 1970). Whereas Bleuler deemphasized

positive or psychotic symptoms in favor of his fundamental symptoms, Kurt Schneider argued that the pathognomonic symptoms of schizophrenia were in fact the very delusions and hallucinations that Bleuler considered accessory. Schneiderian first rank symptoms are particular types of delusions and hallucinations that Schneider believed to occur only in patients suffering from schizophrenia.

Thus, cross national research such as the IPSS and the US-UK study led to the development of structured interviews, standardized approaches to diagnosis, and a reemphasis on the importance of psychotic symptoms as the characteristic defining features of schizophrenia. The concern about reliability and the emphasis on psychotic symptoms went hand in hand, since psychotic symptoms have an "all or none" quality and are relatively easily delimited from normality.

The cross national studies had a second impact as well. As the data comparing diagnostic practices around the world became available, it was clear that the United States (and the Soviet Union as well) were employing concepts of schizophrenia somewhat different from those prevailing elsewhere in the world. Specifically, their concepts were broader (Cooper et al, 1972; Kendell et al, 1971; Wing et al, 1974; Kazenetz, 1979). The recognition that the American concept of schizophrenia was probably too broad, and certainly out of step with the rest of the world, led to a reappraisal of its boundaries, summarized in a series of articles deriving originally from the Washington University group and presenting the first relatively narrow set of diagnostic criteria to be written for schizophrenia (Feighner et al, 1972; Robins & Guze, 1970). These criteria included such requirements as duration of symptoms of at least six months and the presence of relatively severe psychotic symptoms such as delusions and hallucinations. Investigators also began to argue that it was important to narrow

the concept of schizophrenia in order to conduct adequate research in this illness, since an overbroad definition was likely to pool together within a single concept a potential heterogeneity of conditions and impair the capacity to advance knowledge.

THE INFLUENCE OF CLINICAL EXPERIENCE

In addition to these various forces arising from the research community, a set of forces began to grow from clinical experience as well, also converging toward the conclusion that the American concept of schizophrenia must be narrowed. The introduction of neuroleptic drugs, and later tricyclic antidepressants and lithium carbonate, have had a major impact on American nosology. Once drugs that ameliorated or reduced prominent and debilitating symptoms of schizophrenia, mania, or depression became available, hypotheses were formulated about the underlying neurochemical abnormalities in the brain that might produce these conditions. Medications were seen as a means of developing a "pharmacologic dissection" of the boundaries between disorders. The dopamine hypothesis of schizophrenia was developed, and the related noradrenergic hypothesis followed shortly, both relying heavily on the differential mechanisms by which specific medications affect the process of neural transmission (Carlsson et al, 1963; Creese et al, 1976; Seeman et al, 1976; Schildkraut, 1965).

These developments in basic neuroscience were coupled with clinical observations of how the drugs acted in different groups of patients. As lithium and antidepressants became available, they were used on "treatment refractory schizophrenics" who had not responded well to neuroleptic medications. Clinicians observed that these "schizophrenics" responded to medications designed for affective illness, eventually leading to a recognition that these patients were probably originally misdiagnosed and in fact represented forms of

affective illness rather than schizophrenia. The implications of these clinical observations are obvious: the evidence from the US-UK study and the IPSS that American psychiatrists were overdiagnosing schizophrenia now began to receive clinical and research support and to suggest that the overdiagnosis of schizophrenia might provide a disservice to the patients. In addition, it became steadily more clear that neuroleptics often were not efficacious for affective illness, especially depression, and sometimes worsened it. Clinicians began to realize that there was a serious risk involved in misdiagnosing an affectively ill patient as having schizophrenia, because he might be doomed to longterm treatment on medications that not only would not reduce his affective symptoms, but would add on a variety of extrapyramidal symptoms that could mimic many of the symptoms of schizophrenia such as affective blunting. As the risks for tardive dyskinesia became recognized, still greater support was added to the notion that neuroleptic medications should be used carefully and selectively, targeted primarily to patients with a relatively narrowly defined form of schizophrenia, and not used for illnesses that lacked florid psychotic symptoms such as delusions or hallucinations.

THE DEVELOPMENT OF THE DSM III CONCEPT OF SCHIZOPHRENIA

Thus, by the early to mid 1970s, in the United States there was a growing body of evidence both from research and from clinical experience indicating that diagnosis of schizophrenia should be defined narrowly and used conservatively. The research evidence, based on the various crossnational studies and the emphasis on identifying highly predictive symptoms that could be defined reliably, led to a reemphasis of the importance of florid psychotic or positive symptoms in formulating such definitions, since these symptoms clearly

could be defined reliably. The clinical evidence indicated that psychiatrists must be very sensitive to discriminating various forms of psychosis, must exercise considerable care in deciding to treat with neuroleptics *versus* lithium or antidepressants, and should err on the side of conservatism and treat for affective illness whenever in doubt. This approach would ensure that whenever the differential diagnosis was difficult, the patient would be assigned to a "good prognosis" category, from which he could be removed relatively easily if the prediction were wrong, and would avoid the alternative approach of erroneously assigning him to a poor prognosis category, which would create a self-fulfilling prophecy of bad outcome with no opportunity to produce disconfirmation through treatment since the neuroleptics would not improve depressive symptoms and instead would exacerbate them and even create the clinical appearance of schizophrenia.

The task force to develop DSM-III was appointed in 1972 and developed its formulation of criteria for schizophrenia in the light of this clinical and research evidence. The definition of schizophrenia did not change substantially between DSM-III and DSM-IIIR, and the IIIR definition therefore can easily be used to illustrate the principles embodied in the DSM-III definition.

A simplified summary of the DSM-IIIR criteria appears in Table 1. The first criterion lists the characteristic symptoms of the disorder. As the schematic summary indicates, prominent weight is given to florid psychotic or positive symptoms, such as delusions, hallucinations, or positive formal thought disorder. Among the Bleulerian or negative symptoms, only affective flattening is included, and negative nonpsychotic symptoms alone are not sufficient to make a diagnosis of schizophrenia. Schneiderian symptoms are given some prominence, but are not made the preeminent features used to define the disorder. The second criterion introduces the Kraepelinian notion that the

patient should show some deterioration in functioning. A third criterion excludes patients who have a full affective syndrome from the diagnosis of schizophrenia. With this criterion, all patients previously called schizoaffective have been removed from the category, as have manic and depressive patients with prominent psychotic features even when they are not congruent with mood. This effactively removes a substantial number of patients previously called "good prognosis" schizophrenia. The fourth criterion further narrows the category by requiring chronicity. Brief psychotic episodes are excluded by the requirement that some features of the illness must be present for at least six months. The final criterion excludes patients who have some type of "organic" factor that could initiate or maintain the disorder, such as the intake of drugs that precipitate psychotic symptoms (e.g., LSD or amphetamines) or the occurrence of some focal lesion such as a tumor.

The conceptual core of the American concept of schizophrenia is summarized in Table 2: requirements of psychotic features, established chronicity, and evidence of deterioration, coupled with the exclusion of affective and "organic" features. This definition is relatively narrow and tight, limiting the diagnosis of schizophrenia to severe forms. The wisdom of this definition can be debated, and such debate is currently under way as the concept of schizophrenia is being formulated for DSM-IV. While some clinicians and investigators wonder whether the definition has been made too narrow for the broad variety of purposes that a nosology must serve, including both research and clinical practice, most agree that this definition sucessfully isolates a relatively clearly defined group of patients who share similar phenomenology and outcome and that it therefore represents a substantial improvement over the chaotic and inconsistent definitions of the 1960s.

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"BOUNDARY DISORDERS" OF SCHIZOPHRENIA

Since the DSM-III and DSM-IIIR definition of schizophrenia changed the concept by resetting boundaries, it is useful to reexamine and evaluate the relationship of the disorders not included in this core concept of schizophrenia. These fall into two broad categories: psychotic disorders on the boundary with schizophrenia, and nonpsychotic disorders on the boundary with schizophrenia.

Psychotic "Boundary Disorders"

The psychotic disorders that are on the boundary with schizophrenia are summarized in Table 3. They include four disorders that share many phenomenological characteristics with schizophrenia and therefore are considered relatively closely related to it. Schizophreniform disorder is defined with precisely the same symptomatology as schizophrenia and differs from it only in terms of having a briefer duration. Delusional or paranoid disorder is differentiated from schizophrenia by having an absence of a deteriorating course; the delusions may be similar in content, but cannot be bizarre. The symptomatic criteria for brief reactive psychosis are somewhat different, but in addition, the necessity for identifiable precipitating factors is specified, and the duration is relatively brief (i.e., less than 2 weeks). Schizoaffective disorder shares the defining symptomatic features of schizophrenia with the defining symptomatic features of affective disorder, but is defined longitudinally; in DSM-IIIR, schizoaffective disorder is considered to be present in those cases when psychotic symptoms persist after affective symptoms have cleared.

Schizoaffective disorder is one of the most controversial among the diagnoses included in DSM-III and DSM-IIIR. In the American nomenclature a variety of alternate definitions are also used, especially for research. The Research Diagnostic Criteria, for example, define schizoaffective disorder

purely cross-sectionally and make this diagnosis in those cases when there is simply overlap between the full schizophrenic and affective symptomatic syndrome, thereby including many illnesses that DSM-III and DSM-IIIR treat as mood incongruent psychotic mania or depression within the schizoaffective category; the RDC divides schizoaffective patients into those that are predominantly schizophrenic and those that are predominantly affective (Spitzer et al, 1978).

There is an enormous research literature on schizoaffective disorder that is too extensive to summarize here. A variety of independent validators have been used in order to determine whether schizoaffective disorder is a subtype of schizophrenia, a subtype of affective illness, or a third psychosis; the bulk of this evidence indicates that schizoaffective disorder is a "mixed bag" that includes some patients that closely resemble schizophrenia, others that closely resemble affective illness, and still others that are simply diagnostically difficult (Pope and Lipinski, 1978; Rosenthal et al, 1980; Brockington et al, 1979, 1980; Clayton, 1984; Coryell, 1986; Welner et al, 1974).

For the historical reasons described above, the American concept of schizophrenia has separated apart psychotic illnesses with prominent affective features and classified many of them under the major heading of affective illness. Clinicians all over the world have, of course, recognized for many years that affective disorders are often characterized by prominent psychotic symptoms. Indeed, this was the reason that Bleuler considered psychotic symptoms to be "accessory" and not in any sense specific to or pathognomonic of schizophrenia. Nevertheless, clinicians have also believed that *some* types of psychotic symptoms are more likely to be associated with schizophrenia than affective illness. Schneiderian first rank symptoms represent an attempt to identify such psychotic symptoms, a point of view that was very influential on the

PSE and therefore has shaped the diagnostic formulations of the IPSS and most British research.

During the 1970s, several studies were published that indicated that Schneiderian symptoms could be observed in affective illness and therefore could not be considered pathognomonic of schizophrenia (Pope and Lipinski, 1978; Abrams et al, 1974; Taylor and Abrams, 1975; Taylor, 1972, Carpenter et al, 1973). These studies had a major impact on the DSM-III definitions and categories, leading eventually to the development of a subcategorization of psychotic mania and depression into those with mood congruent psychotic features and those with mood incongruent psychotic features. Mood incongruent psychotic features are characterized by themes consistent with an abnormality in mood, such as delusions of high position in mania. Incongruent features include both Schneiderian symptoms as well as others that are clearly mood incongruent, such as delusions of morbid bodily dysfunction in patients with mania. This broadening of affective illness with mood incongruent symptoms to include severe psychotic illness was decided upon partly for the reasons of clinical utility described above, partly because of the recognition that pathognomonic phenomenology could not be identified, and partly because of studies indicating good treatment response and outcome in cases of severe psychotic mania and depression. It is a relatively arbitrary distinction involving a difficult clinical boundary, and one that will be subjected to continual scrutiny and review, as is currently being done in the development of DSM-IV.

Nonpsychotic "Boundary Disorders"

In addition to "boundary disorders" that share psychotic features with schizophrenia, there is another group of "boundary disorders" that are nonpsychotic. These are summarized in Table 4. Just as the concept of

schizophrenia was narrowed in DSM-III by removing those disorders with prominent affective features and placing them under the affective heading, it was further narrowed by removing nonpsychotic disorders and placing them under the heading of personality disorders. Simple schizophrenia, a nonpsychotic form of schizophrenia characterized by prominent negative symptoms, was removed altogether because little evidence appeared to support either its validity or clinical utility. Pseudoneurotic schizophrenia and latent schizophrenia met the same fate, and for the same reasons. Other spectrum disorders were retained, although typically with new names and/or definitions, reflecting the evolution in research concepts that had occurred during the 1970s. Schizotypal, paranoid and schizoid personality disorders are potentially within the overall spectrum of schizophrenia and its related disorders, while borderline, cyclothymic, and dysthymic personalities are considered to be conceptually related to affective illness.

It is important to review the evolution in thinking behind these divisions, because the literature of the 1950s and 1960s tends to blur and mix together these various spectrum conditions, often using interchangeably terms such as schizotypal, schizoid, borderline, latent or pseudoneurotic. Adding to the confusion is the fact that the very research literature that was used in order to split schizotypal and borderline apart from schizophrenia, and ultimately to see schizotypal disorder as related to schizophrenia and borderline to affective illness, itself uses the terms interchangeably at times (Rosenthal et al, 1971; Kety et al, 1971).

The history of the existing American definitions of borderline and schizotypal personality disorders has been summarized by Spitzer et al. (1979). Briefly, the items used to define schizotypal personality were developed in consultation with , Kety, Rosenthal, and Wender who had used these terms in their landmark

adoption and family studies (1971). Wender, Kety and Rosenthal provided the DSM group with the list of cues that they had used in order to identify those cases whom they referred to in their adoption studies as borderline schizophrenia. These were subjected to a variety of statistical analyses, as well as a comprehensive review of 36 family study records diagnosed as borderline schizophrenia, leading eventually to the identification of 17 items thought to be potentially useful in identifying this concept. Independently, defining features for borderline personality (at that time referred to as unstable personality) were gleaned through the psychoanalytic literature, particularly emphasizing the work of Gunderson et al (1975), Kernberg (1967), Grinker et al (1968) and Stone (1978). This yielded a group of 9 items. After these item sets were identified, the total of 22 items were mixed and submitted to practicing American psychiatrists, who were asked to relate these items to patients whom they knew clinically and who had a diagnosis of either borderline personality, borderline personality organization, or borderline schizophrenia. The resulting 808 questionnaires were subjected to factor analysis and discriminant function analysis in order to identify which were most useful in categorizing patients as having borderline schizophrenia *versus* the unstable or borderline personality condition. The items useful in this differentiation are summarized in Tables 4 and 5. The number of items required to diagnose either of these two disorders as present or absent was also determined, using different cut-off thresholds and analyzing the sensitivity and specificity. Cut-off thresholds in the four to five range produced sensitivity and specificity estimates in the 80-90 percent range.

This work provided relatively strong support for the notion that the concept of "borderline" was not unitary but rather represented two different subgroups of patients with nonpsychotic personality syndromes. Ultimately, the term

"unstable" was dropped to refer to one subtype, and the term "borderline" substituted instead. Thus, the two major constructs were designated as schizotypal and as borderline. The schizotypal group has many characteristics that align it phenomenologically to the concept of schizophrenia, such as abnormalities in affect, odd behavior, or odd communication. Essentially, the concept of schizotypal personality represents a disorder characterized by many negative symptoms, coupled with mild "positive-like" symptoms that do not reach full psychotic intensity, such as odd perceptions or odd speech. Borderline personality, on the other hand, has many features in common with affective illness, such as affective instability, feelings of emptiness and loneliness, and suicide attempts.

Subsequent work exploring the validity of these disorders has supported both their discreteness from one another and their differential relationship to core schizophrenia and affective disorders. Family and genetic studies have been particularly useful in this regard (Akiskal et al, 1981, 1985). In accordance with the original adoption literature, subsequent family studies have indicated that features of schizotypal disorder are relatively more common among the first degree relatives of patients suffering from schizophrenia than patients suffering from affective illness or other conditions (Kendler, 1981, 1984; Baron et al, 1983; Torgerson, 1984, 1985; Siever and Gunderson, 1979). The relationship of borderline personality to affective disorder is similarly closely linked familialy and perhaps genetically (Stone, 1979).

Treatment Implications

Within American nosology, these distinctions between the psychotic and nonpsychotic disorders, between schizophrenia and affective disorders, and between nonpsychotic schizophrenia spectrum and affective spectrum

disorders are considered to be important because they have major treatment implications. In an oversimplified and schematic way, these treatment implications are summarized in Table 7.

Schizophrenia and the psychotic forms of affective illness are both considered to be serious conditions and typically to require treatment within a hospital. Within the hospital, however, the mode of treatment differs. Neuroleptic drugs are the first line treatment for schizophrenia, while lithium, tegretol and antidepressants are first line treatments for affective illness. Neuroleptics are used as needed for psychiatric affective illness, particularly in psychotic mania, but attempts are made to use them as parsimoniously as possible, for the shortest time intervals, and only if florid psychotic symptoms are severe and persistent.

The nonpsychotic disorders, on the other hand, are typically treated on an outpatient basis, and medications are rarely used. Many patients with these conditions, in fact, are absorbed within society, viewed as representing mild eccentricities, and not seen within the health care system. This is epecially true of patients with the nonpsychotic schizophrenia spectrum conditions, particularly schizoid personality. Borderline personality, on the other hand, which is the most commonly diagnosed among the affective spectrum conditions, is characterized by sufficient interpersonal and affective instability that treatment is often required. In this instance, however, outpatient psychotherapy is the preferred treatment, and medications are also rarely used. These patients are considered to be quite difficult to manage, and to require relatively intensive psychotherapy.

RELATIONSHIP BETWEEN AMERICAN AND SOVIET NOSOLOGY

Few, if any, Americans can speak with expertise on the Soviet approach to the diagnosis of schizophrenia and related conditions. The Soviet concepts of schizophrenia are summarized in the corresponding paper by Smulevitch. Nevertheless, some tentative comparisons and contrasts, based on existing descriptions in English, are useful in understanding the similarities and differences between the two national systems, each of which exists within the general framework of the International Classification of Disease but has its own national characteristics. The discussion that follows depends heavily on the description of the Soviet approaches developed by Holland and Shakhmatova-Pavlova, which appeared in 1977.

The Soviet approach to classification relies on the work of Snezhnevsky. Schizophrenia is considered to be a lifelong illness and to be genetically based, at least to some degree. Although the course may sometimes involve exacerbations and remissions, even during periods of remission the disease is considered to be present in subclinical form. Three major subtypes are recognized: continuous, shift-like, and periodic.

The continuous form is characterized by an unremitting downward course of deterioration. Within the continuous form, different types are recognized which are based on the rate of progression. The malignant form is characterized by relatively severe positive symptoms and a rapid rate of deterioration. The moderate form shows somewhat less severe symptoms, such as delusional thinking, and resembles the American or Kraepelinian concept of paranoid schizophrenia. The mild or sluggish form is a subpsychotic form in which personality changes are prominent. These may include hysterical symptoms, grandiosity, hypochondriacal symptoms, depersonalization and ideas of reference.

The periodic form of schizophrenia is at the opposite extreme from the continuous form. Patients with this type of schizophrenia have attacks of psychosis which are often characterized by affective symptoms and function normally between attacks with a full *restitudo ad integrum*; thus this form of schizophrenia is considered to be without progression.

The shift-like form of schizophrenia is intermediate between continuous and periodic forms. Patients are considered to have some indices of poor premorbid functioning prior to the onset of the full-blown attack. The shift-like forms of schizophrenia are subdivided into severe, moderate and mild. The severe forms have discrete periods of psychosis with some detectable symptoms, such as delusions, occuring even during periods of remission, and there is a steady tendency to develop emotional defect states as well. The moderate form is also characterized by periods of psychosis; affective symptoms may be quite prominent, and some mild residual symptoms tend to remain present between attacks. The mild form is characterized by similar persecutory ideation and affective symptoms during an attack, with relatively mild symptoms between attacks, such as pseudoneurotic symptoms (obsessions, hypochondriasis, or depersonalization).

The Soviet concept of schizophrenia is clearly considerably broader than the American one. The two major features that differentiate the American concept from the Soviet one are the requirement of psychotic symptoms and the exclusion of patients with prominent affective features. The relationship between the two systems, using the current American nosology, is shown schematically in Table 8. The moderate and malignant forms of continuous schizophrenia appear to be nearly identical to the American concept of core schizophrenia, but sluggish schizophrenia more closely resembles disorders that the American system places within either the schizophrenia spectrum or

affective spectrum: schizotypal personality disorder or borderline personality disorder. The severe form of shift-like schizophrenia is also identical to American schizophrenia, but the moderate form may include some patients with psychotic affective illnesses, and the mild form would almost certainly include some psychotic affectives and possibly some borderlines as well. Given the fact that the DSM approach to schizophrenia requires evidence of deterioration, while the periodic forms of schizophrenia in the Soviet Union permit a *restitutio ad integrum*, the periodic forms are quite different from American schizophrenia. The majority of cases diagnosed as having periodic schizophrenia in the Soviet Union would probably be diagnosed as having schizophreniform disorder, brief reactive psychosis, or psychotic affective disorders in the United States.

In spite of their differences, the American and Soviet approaches to nosology have many things in common. Both countries perceive schizophrenia to be a major mental health problem that should be a primary focus of interest for research psychiatrists and clinicians. Both stress the importance of observing not only cross-sectional phenomenology, but also the long term course of the illness and its effects on personality. Both recognize that schizophrenia has a genetic component and that ultimately this disease must be understood and defined in terms of its pathophysiological mechanisms. Soviet psychiatry is buttressed by the great behavioral conditioning tradition of Pavlov and the great neurobehavioral tradition of Luria, both of which represent perspectives on the study of psychopathology to which many American psychiatrists are sympathetic. Psychiatrists whose interests focus on schizophrenia are particularly appreciative of the careful clinical and descriptive work of Luria, with its emphasis on understanding clinical phenomena in terms of neural localization. Thus, a positive foundation exists for improved communication and research exchange between the countries.

FUTURE DIRECTIONS IN AMERICAN DIAGNOSTIC THINKING

As the above review indicates, American diagnostic thinking is not static. It is steadily evolving as our knowledge base about mental illnesses grows. American diagnostic thinking is currently undergoing a systematic reappraisal as a new task force and specialized work groups prepare a comprehensive revision of the American diagnostic system, which will ultimately be embodied in DSM-IV. Every effort is being made to place decision-making concerning revisions in the hands of work groups, which are composed of five individuals with recognized clinical and research expertise in the specific categories under their domain.

The schizophrenia work group has identified a number of issues that need continued scrutiny and evaluation, so that the category of schizophrenia and its related conditions can be revised in ways that are as constructive as possible. The schizophrenia work group, like all other DSM work groups, will shape its revisions under the constraints of several major sets of guidelines. First and foremost, any revisions that are made must be based on sound research evidence, insofar as this is possible; the major validators for diagnostic categories are agreed to be prognosis, treatment response, genetic and family studies, and neurobiological measures that may assist in the identification of the pathophysiology and etiology of disorders. A second major guideline is the importance of working closely with the World Health Organization on the simultaneous development of DSM-IV and ICD-10, with the goal that American and international systems will be as similar as possible, so that international communication and research can be facilitated.

Many of the areas currently under study by the schizophrenia work group emphasize exploring the boundaries of schizophrenia in relation to other

disorders. Within the psychotic conditions, the boundaries with affective disorder are under examination, with emphasis on the definition and relationship of schizoaffective disorder and mood incongruent affective disorder. Among the nonpsychotic conditions, the placement of schizotypal disorder in particular is under examination, and the possibility is being explored as to whether it should be classified within schizophrenia and related conditions or should remain on Axis II with the personality disorders.

The defining features of schizophrenia are a second major area of investigation. The six month duration criterion, instituted to define schizophrenia first by the St. Louis group in 1970 and later by DSM-III in 1980, is currently being reexamined, largely because ICD-10 requires only one month of symptoms. Also under review are the defining symptoms of schizophrenia. Given the resurgence of interest in negative symptoms in the 1980s, many investigators are wondering whether greater emphasis should be placed on these symptoms as important characteristic and defining features of schizophrenia. A corollary concern is the diagnosis of simple schizophrenia, since it has historically been defined as a nonpsychotic form of schizophrenia characterized by prominent negative symptoms; this subtype is present in ICD-10, has historical importance, and cannot be studied in any adequate way in research if the category is excluded from the nomenclature.

A final issue under review is the overall approach to subtyping, with an ongoing reevaluation of the usefulness of the traditional Kraepelinian subtypes (i.e., hebephrenic, catatonic, paranoid and undifferentiated) and a systematic exploration for other approaches that may have a greater predictive validity. The process of reevaluating these issues and designing DSM-IV has only just begun. Definitive resolution can only occur after systematic reappraisal of the existing literature.

This paper was written for a scientific presentation in Moscow as part of the American-Soviet Psychiatry project. It does not represent the official views of either the American Psychiatric Association or the DSM-IV Task Force.

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Table 1

DSM-IIIR CRITERIA FOR SCHIZOPHRENIA

A. Characteristic symptoms

At least two:
1) delusions of any type
2) hallucinations of any type
3) disorganized speech
4) catatonic behavior
5) affective flattening or inappropriateness

Or one of the following:
1) bizarre delusions (e.g., Schneiderian)
2) nonaffective auditory hallucinations or Schneiderian hallucinations (voices commenting or conversing)

B. Deterioration in functioning

C. Affective disorder excluded

D. Duration of at least six months (including both florid and prodromal symptoms)

E. "Organic" factors excluded (e.g., substance abuse) that could initiate or maintain the disorder

Table 2

CONCEPTUAL CORE OF SCHIZOPHRENIA

Psychotic features must be present
Established chronicity
Evidence of deterioration
Affective features excluded
"Organic" features excluded

Table 3

"BOUNDARY DISORDERS" OF SCHIZOPHRENIA:PSYCHOTIC DISORDERS

Other psychoses related to schizophrenia:

Schizophreniform Disorder (same definition, duration < 6 months)
Delusional (paranoid) Disorder (no deterioration)
Brief Reactive Psychosis (precipitating factors, brief duration)
Schizoaffective disorder (persistence of psychotic symptoms without affective ones)

Other psychoses related to affective disorder:

Mood incongruent psychotic mania or depression
Mood congruent psychotic mania or depression

Table 4

"BOUNDARY DISORDERS" OF SCHIZOPHRENIANONPSYCHOTIC DISORDERS

Schizophrenia "spectrum" disorders

Schizotypal personality
Paranoid personality
Schizoid personality

Affective "spectrum" disorders

Borderline personality
Cyclothymic disorder
Dysthymic disorder

Table 5

DSM-IIIR SYMPTOMS OF SCHIZOTYPAL PERSONALITY

At least five:

Ideas of reference
Excessive social anxiety
Odd beliefs or magical thinking
Unusual perceptual experiences
Odd or eccentric behavior or appearance
Asociality
Odd speech
Inappropriate or constricted affect
Suspiciousness or paranoid ideation

Table 6

DSM-IIIR SYMPTOMS OF BORDERLINE PERSONALITY

At least five:

Unstable and intense interpersonal relationships
Impulsiveness
Affective instability
Inappropriate, intense, or uncontrolled anger
Recurrent suicidal threats, gestures, or behavior
Marked and persistent identity disturbance
Chronic feelings of emptiness and boredom
Frantic efforts to avoid real or imagined abandonment

Table 7

TREATMENT IMPLICATIONS

Psychotic Disorders	
Schizophrenia	Hospitalization, neuroleptics
Affective Disorders	Hospitalization, lithium, tegretol, antidepressants ? Neuroleptics
Nonpsychotic Disorders	
Nonpsychotic Schizophrenia Spectrum Disorder	Outpatient psychotherapy for difficult cases Medications rarely used Many never seen psychiatrically
Nonpsychotic Affective Spectrum Disorders	Outpatient psychotherapy for difficult cases Medications rarely used Some subclinical cases

Table 8

COMPARISON OF THE AMERICAN AND SOVIETAPPROACHES TO CLASSIFICATION

	Schizophrenia and Related Psychoses	*Schizophrenia Spectrum*	*Affective Psychosis*	*Affective Spectrum*
Continuous				
Malignant	S			
Moderate	S			
Sluggish		ST		B
Shiftlike				
Severe	S			
Moderate	S		PAD	
Mild	S		PAD	B
Periodic	SPH, BRP		PAD	

S = Schizophrenia
SPH = Schizophreniform
BRP = Brief reactive psychosis
ST = Schizotypal

PAD = Psychotic affective disorder
B = Borderline